Zuidema & Hess
Family and Cosmetic Dentistry

WELCOME TO OUR OFFICE!

1 : A COUPLE QUESTIONS ABOUT YOU

Today's Date: ___ /___ /___

Name: _____
FIRST MIDDLE LAST

Preferred Name: _____ ☐ Male ☐ Female

Home Address: _____

_____
CITY STATE ZIP CODE

Home Phone #: _____

Work Phone #: _____

Cell Phone #: _____

Email Address: _____

Birthday: ___ /___ /___ **Age:** ____

Social Security #: _____

Employer: _____

Occupation: _____

Who can we thank for referring you to our office?

Family _____ **Friend** _____ **Internet** _____

Yellow Pages _____ **Radio** _____ **Other** _____

Other family members seen by us: ☐ spouse ☐ children ☐ parents ☐ siblings

Names: _____

In the event of an emergency, whom should we contact?

Their name: _____ **Phone #:** _____ **Relationship:** _____

2 : DENTAL INSURANCE

Do you have dental insurance? ☐ **yes** ☐ **no**

Insured Name: _____

Insured SS#: _____

Insured Date of Birth: ____ /____ /____

Insured Employer: _____

Insurance Co. Name: _____

Insurance ID #: _____

Insurance Co. Address: _____

Insurance Co. Phone#: _____

Group # (plan, local, or policy): _____

Secondary Dental Insurance
If patient has secondary dental insurance and patient is covered under the policy, complete the following:

Insurance Co. Name: _____

Insurance ID #: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (plan, local, or policy): _____

Spouse's Name: _____

Insured Date of Birth: ____ /____ /____ **SS#:** _____

Spouse's Employer: _____

Please list other family members covered by this dental insurance:

_____

AUTHORIZATION

I hereby authorize payment directly to Dr. Lee Zuidema and Dr. Jeremy Hess of the group insurance benefits, otherwise payable to me. **I understand that I am responsible for all costs of dental treatment.** I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals. **In the event that a health care worker comes in contact with my blood or other potentially infectious bodily fluids while treating me, I hereby consent to a hepatitis and HIV antibody test.** These tests will be at no charge to myself.

X _____ **Date:** ____ /____ /____

SIGNATURE I understand that typing my first and last name constitutes a legal electronic signature.

3 : MEDICAL HISTORY

Patient's Name: _____

Physician's Name: _____

Phone #: _____ **Date last seen:** ____ /____ / ____

Your current physical health is: ☐ good ☐ fair ☐ poor

List any prescription or over-the-counter drugs you are taking:

_____ _____

_____ _____

_____ _____

List any herbal supplements you are taking:

_____

Are you allergic to any of the following?

Penicillin	☐ yes
Tetracycline	☐ yes
Erythromycin	☐ yes
Codeine	☐ yes
Sulfa	☐ yes
Ibuprofen	☐ yes
Aspirin	☐ yes
Dental Anesthetics *(Novocaine, Epinephrine, etc.)*	☐ yes
Latex	☐ yes
Metals	☐ yes
Acrylic	☐ yes

Please list any other drugs / foods / compounds that you are allergic to:

_____

For Women:

Are you taking birth control pills?	☐ yes
Are you pregnant?	☐ yes (week #____)
Are you nursing?	☐ yes

For Men:

Do you take nitroglycerin?	☐ yes
Are you taking Viagra?	☐ yes

Have you ever had any of the following diseases or medical problems?

Heart Attack	☐ yes
Heart Murmur	☐ yes
Heart Surgery	☐ yes
Congenital Heart Defect	☐ yes
Mitral Valve Prolapse	☐ yes
Pacemaker	☐ yes
Rheumatic Fever	☐ yes
High Blood Pressure	☐ yes
Low Blood Pressure	☐ yes
Artificial Valves	☐ yes
Atrial Fibrillation	☐ yes
Stroke	☐ yes
Hemophilia / Blood Disorder	☐ yes
Blood Transfusions	☐ yes
HIV + / AIDS	☐ yes
Anemia	☐ yes
Acid Reflux	☐ yes
Tuberculosis	☐ yes
Asthma	☐ yes
Difficulty Breathing	☐ yes
Emphysema	☐ yes
Sleep Apnea	☐ yes
Radiation	☐ yes
Cancer / Chemotherapy	☐ yes
Shingles	☐ yes
Kidney Disease	☐ yes
Artificial Bones / Joints	☐ yes
Diabetes	☐ yes
Hepatitis	☐ yes
Psychiatric Problems	☐ yes
Epilepsy / Seizures	☐ yes
Cold Sores / Herpes	☐ yes
Drug / Alcohol Addiction	☐ yes
Venereal Disease	☐ yes
Ulcers / Colitis	☐ yes
Arthritis	☐ yes
Frequent Headaches	☐ yes
Sinus Problems	☐ yes
Glaucoma	☐ yes

Please list any serious medical condition(s) past or present:

_____

_____

_____

4 : DENTAL HISTORY

Why have you come to the dentist today? _____

_____

Are you currently in pain? ☐ yes ☐ no

Who was your previous dentist? _____

When was your last dental visit? _____

What treatment was done at your last visit? _____

_____

Have you ever had a difficult or serious problem associated with any previous dental work? ☐ yes ☐ no

If "yes," please describe: _____

_____

Your current dental health is: ☐ good ☐ fair ☐ poor

Do you like your smile? ☐ yes ☐ no

Do your gums ever bleed? ☐ yes ☐ no

How many times a week do you floss?
☐ 0 ☐ 1-3 ☐ 4-6 ☐ Daily

How many times a week do you brush?
☐ 1-3 ☐ 4-6 ☐ Daily ☐ 2x Daily

Type of bristles? ☐ hard ☐ med. ☐ soft

Do You:

Experience headaches frequently? ☐ yes _____ Times per week

Experience neck pain frequently? ☐ yes _____ Times per week

Expreience jaw pain frequently? ☐ yes _____ Times per week

Experience snoring? ☐ yes _____ Times per week

Wake up frequently? ☐ yes _____ Nights per week

Feel tired during the day? ☐ yes _____ Days per week

Use a C-Pap Machine? ☐ yes _____ If so, how often?

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

X _____ Date: ____ /____ /____

SIGNATURE I understand that typing my first and last name constitutes a legal electronic signature.

5 : COSMETICS

Do you like the color of your teeth?
☐ yes ☐ no

Do you like the shape and size of your teeth? ☐ yes ☐ no

Are you happy with the alignment of your teeth? ☐ yes ☐ no

What is it that you wish could be changed to improve your smile?

_____

_____

6 : TMJ

Do you have a clicking, popping, or grating noise in your right or left jaw joint? ☐ yes ☐ no

Has the noise changed since it began?
☐ yes ☐ no

Do you have pain when you chew?
☐ yes ☐ no

Do you have pain when you open wide?
☐ yes ☐ no

When did you first notice the pain or noise?

_____

_____

Has your mouth ever locked open or closed? ☐ yes ☐ no

Do you grind your teeth?
☐ yes ☐ no

Have you had a change in your lifestyle such as a change in marital status, childbirth, death in the family, or other stressful events? ☐ yes ☐ no