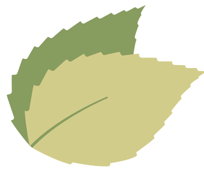


Zuidema & Hess
Family and Cosmetic Dentistry

WELCOME TO OUR OFFICE!

1 : A COUPLE QUESTIONS ABOUT YOU

Today's Date: ____ /____ /____

Instructional note: when answering questions with multiple choice options, please circle the answer(s) that apply to you.

Name: ____
FIRST MIDDLE LAST

Preferred Name: ______________________ ☐ **Male** ☐ **Female**

Home Address: ____
STREET ADDRESS

____
CITY STATE ZIP CODE

Work Phone #: ______________________

Cell Phone #: ______________________

Email Address: ____

Birthday: ____ /____ /____ **Age:** __________

Employer: ____

Occupation: ____

Who can we thank for referring you to our office?

☐ **Internet** ☐ **Insurance** ☐ **Google** ☐ **Facebook**

☐ **Family:** ______________ ☐ **Friend:** ______________ ☐ **Other:** ______________

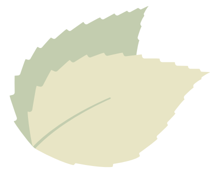
Other family members seen by us: ☐ **spouse** ☐ **children** ☐ **parents** ☐ **siblings**

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 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: ____ /____ /_________

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

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 ☐ yes
  (Lidocaine, Epinephrine, etc.)
- 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

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

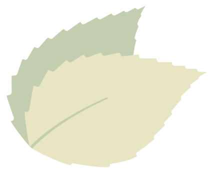
- Heart Attack ☐ yes
- Heart Murmur ☐ yes
- Heart Surgery ☐ yes
- Congenital Heart Defect ☐ yes
- Mitral Valve Prolapse ☐ yes
- Pacemaker ☐ yes
- Rheumatic Fever ☐ yes
- High Blood Pressure ☐ yes
- Low Blood Pressure ☐ yes
- Artificial Valves ☐ yes
- Atrial Fibrillation ☐ yes
- Stroke ☐ yes
- Hemophilia / 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

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