Welcome!

We would like to welcome you to our office. Our goal is to make everyone's visit pleasant and educational. We strive to teach good oral care that will enable you to have a beautiful smile that last a lifetime. Please visit us at www.sawgrassdental.com

1 Patient Information

Today's Date ____________

First Name ______________________________ MI ______

Last Name ______________________________

Birthdate ____________ Age ____ SS# ______________

☐ Married ☐ Single ☐ Widowed ☐ Divorce ☐ Separated

Address ______________________________

____

Home # ____________ Cell # ____________

Employer ____________ Work # ____________

Occupation ______________________________

Email ______________________________

Referred by ______________________________

2 Responsible Party

First Name ______________________________ MI ______

Last Name ______________________________ ☐ M ☐ F

Birthdate ____________ Age ____ SS# ______________

Employer ____________ Work# ____________

Occupation ______________________________

Employer's Address ______________________________

____

3 Primary Dental Insurance

Insurance Co. Name ______________________________

Insurance Co. Address ______________________________

Insurance Co. Phone ______________________________

Plan ____________ Group ____________ Policy ____________

Policy Owners Name ______________________________

Relationship to Patient ______________________________

Policy Owners Birthdate ____________ SS# ____________

Policy Owners Employer ______________________________

Employees Address ______________________________

Orthodontic Coverage? ☐ Yes ☐ No

4 Secondary Dental Insurance

Insurance Co. Name ______________________________

Insurance Co. Address ______________________________

Insurance Co. Phone ______________________________

Plan ____________ Group ____________ Policy

Policy Owners Name ______________________________

Relationship to Patient ______________________________

Policy Owners Birthdate ____________ SS# ____________

Policy Owners Employer ______________________________

Employees Address ______________________________

Orthodontic Coverage? ☐ Yes ☐ No

5 Dental History

Purpose of todays visit ______________________________

Previous dentist ______________________________

When was your last visit ______________________________

What was done ______________________________

Last Cleaning ______________________________

How often do you brush ________ Gums bleed ☐ Yes ☐ No

Any ☐ Sensitive teeth ☐ Loose teeth ☐ Broken Fillings ☐ Jaw pain ☐ Injuries to teeth

Explain ______________________________

Unpleasant Dental Experience ☐ Yes ☐ No

Explain ______________________________

Have you ever had ☐ Orthodontics ☐ Gum Treatment ☐ Root Canal ☐ Oral Surgery ☐ Crowns ☐ Veneers ☐ Implants

Are you happy with the appearance of your teeth?
☐ Yes ☐ No ☐ Color ☐ Position ☐ Smile

Have you ever had tooth whitening? ☐ Yes ☐ No
☐ In Office ☐ Overnight ☐ Drug Store

Are you interested in replacing any missing teeth? ☐ Yes ☐ No

Which method ☐ With Dentures ☐ Bridges ☐ Implants

Do you have any questions for the doctor? ☐ Yes ☐ No

(please continue on back)

I authorize the doctor to perform all recommended treatment agreed upon by me and to use the appropriate medication and therapy for such treatment in connection with ______________________ (NAME OF PATIENT). I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and give consent to the doctor to use and employ such assistant as deemed fit to provide recommended treatment.

6 Medical History

Physicians Name ______________________

Office Address ______________________

Telephone ______________________

Are you currently under the care of a physician? ☐ Yes ☐ No

Explain ______________________

Has there been a recent change to your health? ☐ Yes ☐ No

Explain ______________________

Are you currently taken any prescription, over the counter of recreational drugs? ☐ Yes ☐ No

Explain ______________________

Have you been hospitalized or had a serious illness within the past five years? ☐ Yes ☐ No

Explain ______________________

Please mark any allergies/adverse reactions:

Y N Penicillin
Y N Tetracycline
Y N Erythromycin
Y N Sulfa
Y N Local Anesthetics
Y N Codeine
Y N NSAID (Advil/Motrin)
Y N Aspirin
Y N Valium
Y N Barbiturates
Y N Latex
Y N Iodine
Y N Household Bleach
Other ______________________

Do you?

☐ Smoke Packs Per Day? ________ How Long? ________
☐ Chew Tobacco
☐ Drink Per Week? ________ Per Month? ________
☐ Wear Contact Lenses

a) Are you pregnant or think you may be pregnant? ....Y N
b) Are you nursing? ....Y N
c) Are you taking oral contraceptives?..........................Y N

Check if you have or ever had

Y N Artificial Limb/joint/hip
Y N High/low Blood Pressure
Y N Organ Transplant
Y N Sinus Problems
Y N Migraines
Y N Frequent Headaches
Y N Claustrophobia
Y N Artificial Heart Valve
Y N Prolonged Bleeding
Y N Ulcers/colitis
Y N Hay Fever
Y N Head Injury
Y N Venereal Disease
Y N Mitral Valve Prolapse
Y N Anemia
Y N Acid Reflux
Y N Arthritis
Y N Epilepsy/seizures
Y N STD
Y N Rheumatic Fever
Y N Radiation Therapy
Y N Stomach Problems
Y N Glaucoma
Y N Dizziness/Fainting Spells
Y N Treated For AIDS, HIV, ARC
Y N Heart Murmur
Y N Thyroid Problems
Y N Used Phen Phen
Y N Chronic Diarrhea
Y N Stroke TIA
Y N Joint Surgery
Y N Cancer/chemotherapy
Y N Blood Disorder
Y N Increased Frequent Urination
Y N Bells Palsy
Y N Heart Disease
Y N Diabetes
Y N Asthma
Y N Night Sweats
Y N Psychiatric Or Emotional
Y N Recurrent Infections
Y N Angina
Y N Kidney Problems
Y N Bronchitis
Y N Addictions
Y N Pace Maker
Y N Liver Problems
Y N Emphysema
Y N TMJ Problems
Y N Shortness Of Breath
Y N Hepatitis: A or B or C
Y N Tuberculosis
Y N Unexplained Weight Loss
Y N Mouth Ulcers

7 Office Policy

We reserve the right to charge for any cancelled appointments if we do not receive 48 hours notice. All accounts sent to collections will be charged the account balance plus an additional 50% based on the account balance. Regardless of insurance, patients are fully responsible for any account balance. Patients are encouraged to ask all relevant dental & medical questions and thus fully understand the cost, time, limitations, and potential complications of any dental care they agree to receive. The dental profession can not be responsible for any treatment failures that are the result of patient neglect, injury or abuse. By my signature I hereby do certify that: I have read and understood the office policy. All information I have provided is accurate. I will update the office regarding any changes in this information. I will not hold any member of the dental staff responsible for actions resulting from any errors or omissions that I have made in the completion of this form. *Note: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.* I certify that I have read and understand the above. I acknowledge that my questions, if any, have been answered to my satisfaction. I will not hold my dentist, or any other member of his or her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.
Our Legal Duty: We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect 04/14/2003 and will remain in effect until we replace it.
Accept Assignment: My signature authorizes the release of necessary information needed to process my claim, and to pay benefits to the provider of service.

____
SIGNATURE OF PARENT OR GUARDIAN DATE

8 For Completion By Dentist

Comments on patient interview concerning health history

____

____

____

Significant findings from questionnaire or oral interview

____

____

____

Dental Management considerations

____

____

____
SIGNATURE OF DENTIST DATE

SECTION 3

Dental History (Patient To Fill Out Completely)

Primary reason for this dental appointment: ☐ Examination ☐ Emergency ☐ Consultation

Date of your last dental visit____________________ For what?____

Question	Yes	No
Date of your last dental cleaning ______________________________________		
Do you have a specific dental problem? Describe______________________________	☐	☐
What kind of dental procedures have you had done in the past?__________________		
Do you have any sensitive teeth?____	☐	☐
Have you ever had a toothache or a fractured tooth? ___________________________	☐	☐
Have you ever had periodontal problems?___________________________________	☐	☐
Do you like your smile? Why? ____	☐	☐
Does food catch between your teeth or do you have areas that are difficult to floss? ______________	☐	☐
Does loss of teeth tend to run in your family?_______________________________	☐	☐
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? ____________	☐	☐
Have you ever had Orthodontics (Braces)? ___________________________________	☐	☐
Have your past experiences in a dental office always been positive? ______________	☐	☐
Do you smoke or chew tobacco? Any sores or growths in your mouth? Describe____________	☐	☐
Name of previous dentist (Optional)_______________________________________		
Why did you leave your last dentist? _______________________________________		
Have you noticed spots or stains on your teeth that concern you? __________________	☐	☐
Anything else that concerns you about the appearance of your teeth? ________________	☐	☐
If you could change anything about your smile, what would you change?______________		

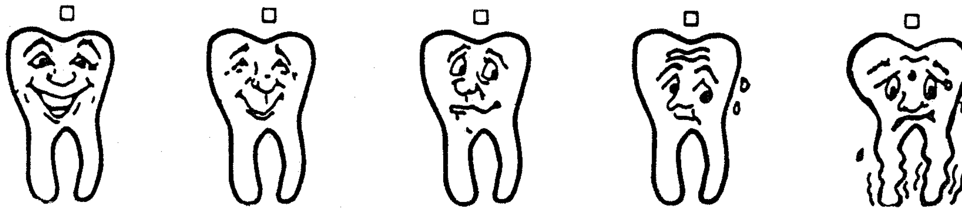
____

Do you have a denture or partial denture? ☐ No ☐ Yes How old are they? _______How do you like them? ______

____

Have you ever required Nitrous Oxide (Laughing Gas) or sedatives for your dental treatment? _________________ ☐ ☐

Check Your Level of Bravery: Don't Worry, We Cater To Cowards



SECTION 4

Initial Clinical Exam (I.C.E.)

Date:______________________________ Patient Name:____

Blood Pressure: ________ : _______

Stains:	☐No	☐Lt	☐Mod	☐Hvy
Calculus:	☐No	☐Lt	☐Mod	☐Hvy
Plaque:	☐No	☐Lt	☐Mod	☐Hvy
Bleeding:	☐No	☐Lt	☐Mod	☐Hvy

TMJ: ☐Asymptomatic ☐Symptoms: ____

Homecare: Brushing: ____ x/day Floss:______ x/week

Perio Diag: ☐Normal ☐Gingivitis ☐Early Perio ☐Mod Perio ☐Adv Perio ☐Maint

Instructions: ☐Brush ☐Floss ☐Perio Aid ☐Other:______________________

Ortho: Occlusal Type: ☐CLI ☐CLII ☐CL III

Soft Tissue Screening

Cancer Exam: ☐Normal ☐Lesion: Describe ____

See dental history for smoking history

	Normal	***Abnormal***
Lips	☐	☐ ____________________
Mucosa	☐	☐ ____________________
Palate	☐	☐ ____________________
Tongue	☐	☐ ____________________
Floor	☐	☐ ____________________
Glands	☐	☐ ____________________
Pharynx	☐	☐ ____________________

Upper Right	Upper Anterior	Upper Left
Lower Right	Lower Anterior	Lower Left

Maximum Pocket Depth Per Sextant in mm

Recall: ______Months Doctor's Signature: Reviewed by: ____________________________________