

# Welcome

Thank you for selecting our dental healthcare team!  
We will strive to provide you with the best possible dental care.  
To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

## Patient Information (CONFIDENTIAL)

Patient # \_\_\_\_\_  
Date \_\_\_\_\_  
Name \_\_\_\_\_ Birthdate \_\_\_\_\_ SS# \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Email \_\_\_\_\_ Home Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Emergency Phone \_\_\_\_\_  
Check Appropriate Box:  Minor  Single  Married  Divorced  Widowed  Separated  
If Student, Name of School / College \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  Full Time  Part Time  
Patient or Parent/Guardian's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Spouse's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Whom May We Thank for Referring You? \_\_\_\_\_  
Person to Contact in Case of Emergency \_\_\_\_\_ Phone \_\_\_\_\_

## Responsible Party

Name of Person Responsible for this Account \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
Email \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Driver's License # \_\_\_\_\_ SS# \_\_\_\_\_  
Is this Person Currently a Patient in our Office?  Yes  No

## Insurance Information

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Birthdate \_\_\_\_\_ SS #/SIN \_\_\_\_\_ Date Employed \_\_\_\_\_  
Name of Employer \_\_\_\_\_ Union or Local # \_\_\_\_\_ Work Phone \_\_\_\_\_  
Address of Employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Policy/ID # \_\_\_\_\_  
Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
How Much is your Deductible? \_\_\_\_\_ How Much Have You Used? \_\_\_\_\_ Max. Annual Benefit \_\_\_\_\_

DO YOU HAVE ANY ADDITIONAL INSURANCE?  Yes  No IF YES, COMPLETE THE FOLLOWING:

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Birthdate \_\_\_\_\_ SS #/SIN \_\_\_\_\_ Date Employed \_\_\_\_\_  
Name of Employer \_\_\_\_\_ Union or Local # \_\_\_\_\_ Work Phone \_\_\_\_\_  
Address of Employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Policy/ID # \_\_\_\_\_  
Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
How Much is your Deductible? \_\_\_\_\_ How Much Have You Used? \_\_\_\_\_ Max. Annual Benefit \_\_\_\_\_

Over Please

# Patient Medical History

Physician \_\_\_\_\_ Office Phone \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

1. Are you under medical treatment now?  Yes  No
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?  
If yes, please explain \_\_\_\_\_
3. Are you taking any medication(s) including non-prescription medicine?  Yes  No  
If yes, what medication(s) are you taking? \_\_\_\_\_
4. Have you ever taken any bisphosphonates (such as Actonel or Fosamax)  Yes  No
5. Do you use tobacco?  Yes  No
6. Do you use controlled substances?  Yes  No
7. Are you wearing contact lenses?  Yes  No
9. Are you allergic to or have you had any reactions to the following?  

Local Anesthetics (e.g. Novocain)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Penicillin or other Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa Drugs	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates	<input type="checkbox"/>	<input type="checkbox"/>
Sedatives	<input type="checkbox"/>	<input type="checkbox"/>
Iodine	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Any Metals (e.g. nickel, mercury, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Latex Rubber	<input type="checkbox"/>	<input type="checkbox"/>
Other (please list) _____	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)  Yes  No
11. Women Only:  
 a) Are you pregnant or think you may be pregnant?  Yes  No  
 b) Are you nursing?  Yes  No  
 c) Are you taking oral contraceptives?  Yes  No

8. Do you have or have you had any of the following?
- |                        |                              |                             |                              |                              |                             |                       |                              |                             |
|------------------------|------------------------------|-----------------------------|------------------------------|------------------------------|-----------------------------|-----------------------|------------------------------|-----------------------------|
| High Blood Pressure    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart Disease                | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Chest Pains           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart Attack           | <input type="checkbox"/>     | <input type="checkbox"/>    | Cardiac Pacemaker            | <input type="checkbox"/>     | <input type="checkbox"/>    | Easily Winded         | <input type="checkbox"/>     | <input type="checkbox"/>    |
| Rheumatic Fever        | <input type="checkbox"/>     | <input type="checkbox"/>    | Heart Murmur                 | <input type="checkbox"/>     | <input type="checkbox"/>    | Stroke                | <input type="checkbox"/>     | <input type="checkbox"/>    |
| Swollen Ankles         | <input type="checkbox"/>     | <input type="checkbox"/>    | Angina                       | <input type="checkbox"/>     | <input type="checkbox"/>    | Hay Fever / Allergies | <input type="checkbox"/>     | <input type="checkbox"/>    |
| Fainting / Seizures    | <input type="checkbox"/>     | <input type="checkbox"/>    | Frequently Tired             | <input type="checkbox"/>     | <input type="checkbox"/>    | Tuberculosis          | <input type="checkbox"/>     | <input type="checkbox"/>    |
| Asthma                 | <input type="checkbox"/>     | <input type="checkbox"/>    | Anemia                       | <input type="checkbox"/>     | <input type="checkbox"/>    | Radiation Therapy     | <input type="checkbox"/>     | <input type="checkbox"/>    |
| Low Blood Pressure     | <input type="checkbox"/>     | <input type="checkbox"/>    | Emphysema                    | <input type="checkbox"/>     | <input type="checkbox"/>    | Glaucoma              | <input type="checkbox"/>     | <input type="checkbox"/>    |
| Epilepsy / Convulsions | <input type="checkbox"/>     | <input type="checkbox"/>    | Cancer                       | <input type="checkbox"/>     | <input type="checkbox"/>    | Recent Weight Loss    | <input type="checkbox"/>     | <input type="checkbox"/>    |
| Leukemia               | <input type="checkbox"/>     | <input type="checkbox"/>    | Arthritis                    | <input type="checkbox"/>     | <input type="checkbox"/>    | Liver Disease         | <input type="checkbox"/>     | <input type="checkbox"/>    |
| Diabetes               | <input type="checkbox"/>     | <input type="checkbox"/>    | Joint Replacement or Implant | <input type="checkbox"/>     | <input type="checkbox"/>    | Heart Trouble         | <input type="checkbox"/>     | <input type="checkbox"/>    |
| Kidney Diseases        | <input type="checkbox"/>     | <input type="checkbox"/>    | Hepatitis / Jaundice         | <input type="checkbox"/>     | <input type="checkbox"/>    | Respiratory Problems  | <input type="checkbox"/>     | <input type="checkbox"/>    |
| AIDS or HIV Infection  | <input type="checkbox"/>     | <input type="checkbox"/>    | Sexually Transmitted Disease | <input type="checkbox"/>     | <input type="checkbox"/>    | Mitral Valve Prolapse | <input type="checkbox"/>     | <input type="checkbox"/>    |
| Thyroid Problem        | <input type="checkbox"/>     | <input type="checkbox"/>    | Stomach Troubles / Ulcers    | <input type="checkbox"/>     | <input type="checkbox"/>    | Other _____           | <input type="checkbox"/>     | <input type="checkbox"/>    |

## Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

**X**  
 Signature of patient (or parent if minor) \_\_\_\_\_

Doctor's Comments _____ _____ _____ _____ _____	Signature _____ Date _____
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# PATIENT DENTAL HISTORY

PATIENT'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

REASON FOR THIS VISIT \_\_\_\_\_

WHEN WAS YOUR LAST DENTAL VISIT \_\_\_\_\_ WHAT WAS DONE THEN \_\_\_\_\_

HOW OFTEN DID YOU VISIT THE DENTIST BEFORE THEN \_\_\_\_\_

PREVIOUS DENTIST (NAME AND LOCATION) \_\_\_\_\_

HAVE YOU HAD A COMPLETE SERIES OF DENTAL FILMS (X-RAYS) TAKEN WHEN WHERE \_\_\_\_\_

HOW OFTEN DO YOU BRUSH YOUR TEETH \_\_\_\_\_ HOW OFTEN DO YOU FLOSS YOUR TEETH \_\_\_\_\_

	YES	NO		YES	NO
DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING .....	<input type="checkbox"/>	<input type="checkbox"/>	DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY .	<input type="checkbox"/>	<input type="checkbox"/>
ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS .....	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH .....	<input type="checkbox"/>	<input type="checkbox"/>
ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS .....	<input type="checkbox"/>	<input type="checkbox"/>	DOES FOOD TEND TO BECOME CAUGHT BETWEEN YOUR TEETH .....	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU FEEL PAIN TO ANY OF YOUR TEETH.....	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU EVER HAD PERIODONTAL TREATMENT (GUMS).....	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH.....	<input type="checkbox"/>	<input type="checkbox"/>	EVER WORN A BITE PLATE OR OTHER APPLIANCE... ..	<input type="checkbox"/>	<input type="checkbox"/>
HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES .	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST .....	<input type="checkbox"/>	<input type="checkbox"/>
HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?			HAVE YOU EVER HAD ANY PROLONGED BLEEDING FOLLOWING EXTRACTIONS.....	<input type="checkbox"/>	<input type="checkbox"/>
CLICKING .....	<input type="checkbox"/>	<input type="checkbox"/>	DO YOU WEAR DENTURES OR PARTIALS.....	<input type="checkbox"/>	<input type="checkbox"/>
PAIN (JOINT, EAR, SIDE OF FACE) .....	<input type="checkbox"/>	<input type="checkbox"/>	IF YES, DATE OF PLACEMENT _____		
DIFFICULTY IN OPENING OR CLOSING .....	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU EVER RECEIVED ORAL HYGIENE INSTRUCTIONS REGARDING THE CARE OF YOUR TEETH AND GUMS .....	<input type="checkbox"/>	<input type="checkbox"/>
DIFFICULTY IN CHEWING .....	<input type="checkbox"/>	<input type="checkbox"/>			
DO YOU HAVE FREQUENT HEADACHES .....	<input type="checkbox"/>	<input type="checkbox"/>			
DO YOU CLENCH OR GRIND YOUR TEETH .....	<input type="checkbox"/>	<input type="checkbox"/>			

## SMILE EVALUATION

HOLD A FULL FACE MIRROR 12"-14" FROM YOUR FACE. SMILE TO SHOW YOUR TEETH; TAKE THE TIME TO OBSERVE YOUR TEETH CAREFULLY, THEN ANSWER THE FOLLOWING QUESTIONS.

DO YOU LIKE THE APPEARANCE OF YOUR TEETH, YOUR SMILE? ..... YES NO

IF NOT, PLEASE EXPLAIN: \_\_\_\_\_

ARE YOUR TEETH IN ALIGNMENT? ..... YES NO

IF NOT, PLEASE EXPLAIN: \_\_\_\_\_

DO YOU HAVE SPACES YOU DON'T LIKE? ..... YES NO

WHY OR WHY NOT? \_\_\_\_\_

DO YOU LIKE THE COLOR OF YOUR TEETH? ..... YES NO

WHY OR WHY NOT? \_\_\_\_\_

DO YOU LIKE THE SHAPE OF YOUR TEETH? ..... YES NO

WHAT WOULD YOU CHANGE? \_\_\_\_\_

ARE YOUR TEETH: CHIPPED \_\_\_\_\_ PROTRUDING \_\_\_\_\_ HIDDEN \_\_\_\_\_ YES NO

DO YOU LIKE THE WAY YOUR TEETH COME TOGETHER? ..... YES NO

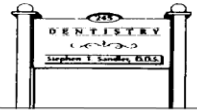
ARE THERE ANY OLD FILLINGS OR DENTAL WORK THAT YOU DON'T LIKE? ..... YES NO

WHY NOT? \_\_\_\_\_

IF YOU HAD A MAGIC WAND, WHAT WOULD YOU CHANGE ABOUT YOUR SMILE? \_\_\_\_\_

DOCTOR'S COMMENTS \_\_\_\_\_

\_\_\_\_\_  
 SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_



To Our Valued Patient,

This year marks the beginning of many exciting changes in our office in our effort to improve service and quality of care for you so that you can regain and maintain your health as quickly and efficiently as possible.

We believe that through a mutual understanding and agreement of the following office guidelines, our team will be able to concentrate on providing you with the highest standards of dental care and service possible:

1. We expect timelines of ourselves and you. We do our best to adhere to your appointment time. If you are more than 10 minutes late, you may have to reschedule your appointment. Cleanliness and infection control are of the utmost importance. We have the latest sterilization technology and disinfect each treatment room after every patient. This is another reason why being on time is necessary.
2. We run a zero patient balance. Patient responsibility payment is required in full prior or at the time treatment is provided. We have a financial option for all our patients. Please speak to Natasha if you have any questions.
3. Our policy is to make your experience in our office an exceptional one. When we succeed, we would appreciate you telling your family and friends about our office. If your visit with us did not meet your expectations, please tell us. Your opinion matters and helps us determine the areas where we are doing well and where we can improve.
4. It is critical to maintain your recommended dental schedule in order to avoid setbacks in the care and maintenance of your teeth and gums. If you cannot make an appointment, you are expected to call at least 48 hours prior to your appointment time to reschedule. There will be a \$50 cancellation fee for all missed appointments which will be donated to the Make a Wish Foundation. As a courtesy, our office calls to remind you of your appointment two working days prior. We ask you to call back to confirm your appointment for each and every visit.
5. Our office prides itself on making the very best treatment recommendations for your overall dental health. If you have insurance, it is your responsibility to be aware of what your dental benefits are and to inform our office if there have been any changes to your dental coverage. We will provide you with an estimate of benefits. As a courtesy, our office will fill out all necessary paper work to assist you in reimbursement. However, you are fully responsible for all fees on any treatment performed.
6. It is our goal to eliminate all of the potential dental emergencies you may have by providing care for you before it becomes a problem. In the rare instance that you do have an emergency, please try to be as specific as possible when you are explaining your emergency to our dental team. We will provide you with the next available dental appointment.

Most sincerely yours,

Dr. Sandler and Team

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Patient Signature, Date