We Would Like to Get to Know You Better!

Full name _____ Gender: __Male __Female Date _____

Phone (Hm) (_____) _____ - _____ (Wk) (_____) _____ - _____ (Cell) (_____) _____ - _____

Address _____ City _____ State _____ Zip _____

Email _____ Date of Birth _____/ _____/ _____ Social Security # _____ - ____ - _____

Drivers License # _____ Marital status _____ Spouse's name _____

Occupation _____ Employer _____ Work Hours _____

Contact in case of emergency _____ Phone (_____) _____ - _____

When was your last dental appointment? _____ Person responsible for your dental investment? _____

How did you hear about us? _____ Why did you leave your last dentist? _____

We Want to Take Care of Your Concerns and Needs First…

What are your present dental problems? _____

Do you avoid brushing any part of your mouth?	( ) Yes	( ) No		
Do your gums bleed when brushing?	( ) Yes	( ) No		
Are your teeth sensitive to sweets, hot/cold, or biting pressure?	( ) Yes	( ) No		
I want to know about longer lasting solutions.	( ) Yes	( ) No		
Are you dissatisfied with your teeth and their appearance?	( ) Yes	( ) No		
Does dental treatment make you nervous?	( ) Very	( ) Moderately	( ) Slightly	( ) No
I think my dental health is…	( ) Excellent	( ) Good	( ) Fair	( ) Poor
If I could change my smile I would make my teeth…	( ) Whiter	( ) Straighter	( ) Close Spaces	( ) Repair Chips

Other concerns/needs of mine are _____

For Insurance Purposes…

Name of policy holder_____ Policy holder Social Security # _____ - _____ - _____

Policy holder's date of birth_____ Employer_____ Name of Ins. Co._____

Insurance company's Phone_____ Group #_____ Ins. Co. Address_____

Are you covered by another plan? If so please complete the following…

Name of policy holder_____ Policy holder Social Security # _____ - _____ - _____

Policy holder's date of birth_____ Employer_____ Name of Ins. Co._____

Insurance company's Phone_____ Group #_____ Ins. Co. Address_____

I certify that I, and/or my dependent(s), have insurance coverage and assign directly to Horizons Dentistry all insurance benefits, if any, otherwise payable to th Dr. for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named dentist may use my health care information and may disclose such information to my insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Patient Signature:_____ Date:_____ Relationship to patient_____

HEALTH QUESTIONNAIRE

PatientName:_____ Birth Date:___Gender: __Male __Female

Dental History

Place a mark to inicate if you have had any of the following:

- ○ Yes ○ No Bad breath
- ○ Yes ○ No Dry mouth
- ○ Yes ○ No Grinding teeth
- ○ Yes ○ No Fingernail biting
- ○ Yes ○ No Mouth breathing
- ○ Yes ○ No Blisters on lip or mouth
- ○ Yes ○ No Orthodontic Treatment
- ○ Yes ○ No Jaw Pain or Tiredness
- ○ Yes ○ No Clicking or Popping Jaw
- ○ Yes ○ No Periodontal treatment
- ○ Yes ○ No Lip or cheeck biting
- ○ Yes ○ No Burning sensation on tongue
- ○ Yes ○ No Sores or growths in your mouth
- ○ Yes ○ No Cigarette, pipe or cigar smoking
- ○ Yes ○ No Food collection between teeth
- ○ Yes ○ No Loose teeth or broken fillings
- ○ Yes ○ No Chew on one side of mouth

How many times a day do you brush?_____ How many times a week do you floss?_____

Medical History

List any medications you are currently taking and the correlating diagnosis. Including all over-the-counter medications and herbs:_____

Place a mark to indicate if you have had any of the following:

Y	N		Y	N		Y	N		Y	N	
☐	☐	*Pre-Med	☐	☐	AIDS	☐	☐	Allergy - Latex	☐	☐	Nervous Disorders
☐	☐	Allergy - Penicillin	☐	☐	Allergy - Sulfa	☐	☐	Anemia	☐	☐	Cortisone Treatments
☐	☐	Artific. Heart Valve	☐	☐	Artificial Joints	☐	☐	Asthma	☐	☐	Back Problems
☐	☐	Blood Disease	☐	☐	Cancer	☐	☐	Other	☐	☐	Cough, persis/bloody
☐	☐	Epilepsy	☐	☐	Tumors	☐	☐	Pacemaker	☐	☐	Fainting/Dizziness
☐	☐	Diabetes	☐	☐	HIV	☐	☐	Chemotherapy	☐	☐	Congen. Heart Lesion
☐	☐	Glaucoma	☐	☐	Head Injuries	☐	☐	Heart Disease	☐	☐	High Blood Pressure
☐	☐	Heart Trouble	☐	☐	Hep-A	☐	☐	Heart Murmur	☐	☐	Low Blood Pressure
☐	☐	Herpes	☐	☐	Hep-B	☐	☐	Implants	☐	☐	Radiation Treatment
☐	☐	Jaundice	☐	☐	Hep-C	☐	☐	Liver Disease	☐	☐	Respiratory Problems
☐	☐	Mental Disorders	☐	☐	Kidney Disease	☐	☐	Allergy - Other	☐	☐	Sinus Problems
☐	☐	Venereal Disease	☐	☐	Pneumonia	☐	☐	Scarlet Fever	☐	☐	Circulatory Problems
☐	☐	Rheumatic Fever	☐	☐	Rheumatism	☐	☐	Tuberculosis	☐	☐	Chemical Dependency
☐	☐	Stomach Problems	☐	☐	Stroke	☐	☐	Ulcers	☐	☐	Mitral Valve Prolaps
☐	☐	Excessive Bleeding	☐	☐	Arthritis						

1. Are you in good health? ○ Yes ○ No
2. Are you now under the care of a physician? ○ Yes ○ No
3. The name and address and Phone # of my physician is:

_____

_____

4. Have you ever had a serious illness or operation? ○ Yes ○ No
   If so, what?_____

Women Only
Are you pregnant, nursing or taking birthcontrol pills? ○ Yes ○ No
If pregnant, # of weeks:_____

Updates:

_____
Patient/Guardian Signature DDS Initials Date

_____
Patient/Guardian Signature DDS Initials Date

_____
Patient/Guardian Signature DDS Initials Date

If answer is yes, please circle the condition.

1. Have you ever used any diet drugs such as Pondimin, "Phen-Phen" or "Redux"? ○ Yes ○ No
2. Have you ever been treated with the intravenous bisphosophonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma, Fosamax or metastatic cancer? ○ Yes ○ No
3. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ○ Yes ○ No
4. Do you wear a cardiac pacemaker, or have you had any heart surgery? ○ Yes ○ No
5. Have you ever had a local anesthetic (Novacaine, etc.)? ○ Yes ○ No
6. Have you ever had any unfavorable reaction from a local anesthetic? ○ Yes ○ No
7. Have you had any serious trouble associated with any previous dental treatment? ○ Yes ○ No
8. Do you have any systemic disease, condition, or problem not listed that you think we should know about? ○ Yes ○ No
   If so, what?_____

Patient Signature:_____ Date:_____ Relationship to patient_____

I have read and review all the above information and answered all the questions to the best of my knowledge. Authorization must be signed by the patient, or nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

Doctor Signature:_____ Date:_____