Dawn A. Diesing, D.D.S., PLLC

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PATIENT INFORMATION

Date: _____

Name: _____

Sex ❑ M ❑ F Date of Birth: _____

Address: _____

Residence phone:( ) _____

Cell phone:( ) _____

Social Security No.: _____

Driver's License No.: _____

Your employer: _____

Occupation: _____

Business address: _____

Business phone: ( ) _____ ext. _____

E-mail: _____

May we contact you at work? _____

Whom may we thank for referring you to us? _____

Person responsible for this account: _____

Whom may we contact in an emergency? _____

Is there dental insurance of which we need to be aware _____

_____

Your dental insurance company: _____

_____

Group #: _____

Spouse's dental insurance company:

_____

Group #: _____

Name of spouse: _____

Date of Birth: _____

Address if different: _____

_____

E-mail: _____

Social Security No.: _____

Driver's License No.: _____

Employer: _____

Occupation: _____

Business address: _____

Business phone: ( ) _____ ext. _____

Years with firm: _____

Nearest relative not living with you:

_____

Relation to you: _____

Address: _____

_____

Residence phone: ( ) _____

Business phone: ( ) _____

MEDICAL HISTORY

	YES	NO
1 . Are you in good health?	○	○
2. Has there been any change in your general health within the past year?	○	○
3. My last physical examination was on _____		
4. Are you now under the care of a physician?	○	○
a. If yes, what condition _____		
5. Name of physician _____		
1. Address _____		
2. Phone ( ) _____		
6. Have you had any serious illness or operation?	○	○
a. If yes, what was the illness or operation and when was it? _____		
_____		
7. Do you have or have you ever had any of the following?		
a. Damaged heart valves or artificial valve? _____	○	○
b. Congenital heart lesions? _____	○	○
c. Rheumatic fever? _____	○	○
d. Heart murmur or mitralvalve prolapse _____	○	○
e. Cardiovascular disease (heart attack, angina, high or low blood pressure, arteriosclerosis, stroke)? _____	○	○
f. Do you wear a cardiac pacemaker? _____	○	○
g. Seasonal Allergies, hay fever, or sinus trouble? _____	○	○
h. Emphysema, tuberculosis, or other lung problems? _____	○	○
i. Persistent cough or cough up blood? _____	○	○
j. Diabetes? _____	○	○
k. Hepatitis, jaundice, or other liver disease? _____	○	○
l. Epilepsy? _____	○	○
m. Arthritis, inflammatory rheumatism or artificial joints? _____	○	○
n. Ulcers or colitis? _____	○	○
o. Kidney trouble? _____	○	○
p. Neurological problems? _____	○	○
q. Glaucoma or other eye disorders? _____	○	○
r. Mononucleosis or mumps? _____	○	○
s. Fever blisters or cold sores? _____	○	○
t. Venereal disease? _____	○	○
u. AIDS? _____	○	○
v. Psychiatric care/emotional problems? _____	○	○
w. Asthma _____	○	○
8. Have you ever had abnormal bleeding associated with previous extractions, surgery or trauma?	○	○
9. Have you ever had a blood transfusion?	○	○.
10. Do you have any blood disorder such as anemia, hemophilia?	○	○
11 . Have you ever had surgery, x-ray treatment or chemotherapy for a tumor, growth or any other condition?	○	○
12. Are you taking any of the following?		
a. Antibiotics or sulfa drugs	○	○
b. Anticoagulants (blood thinners)?	○	○
c. Medicine for high blood pressure or other heart problems?	○	○
d. Cortisone (steroids)?	○	○
e. Tranquilizers?	○	○
f. Antihistamines?	○	○
g. Aspirin? ○ 81 mg. ○ full strength	○	○
h. Insulin or oral medicine for diabetes?	○	○
i. Nitroglycerin?	○	○
j. Oral contraceptives (birth control pills)?	○	○
k. Thyroid or other hormonal therapy?	○	○
l. Bisphosphonates: Fosamax, Boniva, Actonel	○	○
m. List all medications you are currently taking: _____		

MEDICAL HISTORY *(cont'd.)*

	YES	NO
13. Are you allergic or sensitive	❍	❍
a. Local anesthetic?	❍	❍
b. Nitrous oxide?	❍	❍
c. Penicillin or other antibiotics?	❍	❍
d. Barbiturates, sedatives, or sleeping pills?	❍	❍
e. Aspirin?	❍	❍
f. Iodine?	❍	❍
g. Codeine or other narcotics? _____	❍	❍
h. Other _____	❍	❍
14. Do you wear contact lenses? _____	❍	❍

15. Women: Are you pregnant? _____ What month? _____ Are you nursing? _____
16. Do you smoke? _____ Packs per day? _____ Do you use smokeless tobacco? _____
17. Do you drink alcohol? _____ How often? _____
18. Do you have any disease, condition, or problem not listed above that I should know about?

_____

_____

_____

DENTAL HISTORY

	YES	NO
1. What is the reason for this appointment? _____		
2. When was your last dental visit? _____ Why? _____		
3. Name of previous dentist _____		
Address _____ Phone ( ) _____		
4. Do you have any fear of dental treatment?	❍	❍
5. Are your teeth sensitive to: ❍ Heat ❍ Cold ❍ Sweets ❍ Biting ❍ Toothbrushing		
Other _____		
6. a) Are you missing any teeth?	❍	❍
b) Have they ever been replaced?	❍	❍
c) If not, why?	❍	❍
7. Have you ever had any of the following treatments:		
❍ Orthodontics (braces) ❍ Endodontics (root canal) ❍ Periodontics (gum)		
❍ Occlusal Bite Adjustment (TMJ) ❍ Bite Splint ❍ Crowns (caps) ❍ Bonding		
❍ Oral Surgery (extractions) ❍ Dentures or partial dentures ❍ Biopsy ❍ Implants		
8. How often do you brush your teeth? _____		
9. a) Do you have difficulty flossing?	❍	❍
b) How often do you floss? _____		
10. Do you have bleeding gums?	❍	❍
11 . Do you have any unpleasant taste or odor in your mouth?	❍	❍
12. Does food get caught between your teeth?	❍	❍
13. Do you clench or grind your teeth?	❍	❍
14. Do you hear popping or clicking noises when you open, close or chew?	❍	❍
15. Do you have any pain in or around your ears?	❍	❍
16. a) Do you ever have headaches, neck aches or a sore jaw?	❍	❍
b) Have you ever had a head, face or neck injury?	❍	❍

Please continue

DENTAL HISTORY *(cont'd.)*

	YES	NO
17. Do you have any biting or chewing habits?		
❍ Fingernails ❍ Pen or pencil ❍ Cheek, tongue or lip ❍ Pipe ❍ Ice		
❍ Other _____		
18. Do you like the appearance of your teeth?	❍	❍
19. Are your front teeth straight?	❍	❍
20. Are your front teeth even in length?	❍	❍
21. Are your teeth all the same color?	❍	❍

22. If you could change your smile, what would you most like to change? _____

_____

_____

CONSENT TO TREATMENT:

I hereby authorize you to take x-rays, study models, photographs, or any other diagnostic aids which you deem appropriate to make a thorough diagnosis of either my dependents' or my dental needs. I also authorize you to perform any and all forms of treatment, medication, and therapy that may be indicated. I understand that the use of anesthetic agents embodies a certain risk and I am willing to accept that risk on behalf of myself and any dependents. I further authorize and consent that you may choose and employ such assistants, hygienists and other personnel as you deem appropriate.

FINANCIAL RESPONSIBILITY:

I understand that dental insurance may be a benefit provided through my employment, that there are numerous types of dental insurance - each of which have different benefit payments and coverage. I agree that it is my responsibility to familiarize myself with the coverage available and to determine what procedures may be covered and the amount of benefits available. I also recognize that I am fully responsible for payment of any and all dental services provided; further, in the sole discretion of this office, my insurance company may be sent a claim as an accommodation and courtesy to me and my dependents.

I further understand that responsibility for payment for any and all dental services provided in this office to me or my dependents is mine, due and payable at the time services are rendered, unless other financial arrangements have been made, in writing. I agree to pay a 1.5% Finance Charge, assessed monthly, on any balance not paid within 30 days of treatment. In the event legal proceedings are necessary to collect any amounts due and owing, I agree to pay the Finance Charge, court costs and reasonable attorney fees incurred to collect the balance due.

Patient _____ Date _____ Witness _____

Patient or Responsible Party _____ Relationship to Patient _____

Notes:

_____

Today's Date

_____

Medications in Use

_____

Drug Allergy or Sensitivity

_____

Recent Surgery

_____

Medical Conditions Currently Being Treated

_____

_____

Other Medical Changes

_____

Signature

_____