David M. Heninger DDS • Justin G. Frandsen DDS

FAMILY & COSMETIC DENTISTRY

PATIENT INFORMATION

Name (first, last, MI) _____ Preferred name _____

Date _____ Email Address _____

Birth date _____ Age _____ Social Security # _____-____-_____ Male Female

Current Address _____ City: _____ State: _____ Zip: _____

Previous Address _____ City: _____ State: _____ Zip: _____

Home Phone (_____)_____ Cell Phone (_____)_____ Work Phone (_____)_____

Driver's License # _____ Employer _____ Years at Employer _____

Employer's Address _____ City: _____ State: _____ Zip: _____

Whom may we thank for referring you to our office? _____

Marital Status: Single Married Separated Divorced Widowed

If full time student, School name _____

EMERGENCY CONTACT INFORMATION

Name of Contact _____ Relationship _____

Contact Home Phone (_____)_____ Contact Work Phone (_____)_____

Contact Address _____ City: _____ State: _____ Zip: _____

Responsible Party for Account (if other than yourself)

Name _____ Relationship _____

Home Phone (_____)_____ Work Phone (_____)_____

Billing Address _____ City: _____ State: _____ Zip: _____

Driver's License # _____ Employer _____ Years at Employer _____

Employer's Address _____ City: _____ State: _____ Zip: _____

If patient is a minor please provide: Mother's Date of Birth_____ Father's Date of Birth_____

SPOUSE INFORMATION

Name _____ Birth date _____ Social Security # _____-____-_____

Work Phone (_____)_____ Employer_____ Driver's License # _____

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER

Policy Holder's Name _____

Policy Holder's DOB _____ SSN#_____

Policy Holder's Employer _____

Insurance Company _____

Insurance Company's Address _____

Insurance Company's Phone # _____

Group # _____ Local # _____

Does your Insurer provide dental coverage? _____

SECONDARY INSURANCE CARRIER
(only if you have double coverage)

Policy Holder's Name _____

Policy Holder's DOB _____ SSN#_____

Policy Holder's Employer _____

Insurance Company _____

Insurance Company's Address _____

Insurance Company's Phone # _____

Group # _____ Local # _____

Does your Insurer provide dental coverage? _____

DENTAL HISTORY

1. Do you have a specific Dental problem? Y N

Describe: _____

2. Do you have dental examinations on a routine basis? Last Visit? Y N
3. Do you think you have active decay or gum disease? Y N
4. Date of Last dental X-rays? Y N
5. Do You brush and floss on a routine basis? Y N

Describe: _____

6. Do your gums Bleed? Y N

Describe: _____

7. Have you ever been treated for gum disease? Y N
8. Does food catch between your teeth? Y N Any loose teeth? Y N
9. Do you have problems with bad breath? Y N
10. Do you have clicking, popping or discomfort in the jaw joint? Y N

    Do you brux or grind? Y N
11. Do you wear dentures ? Y N
12. Would you be interested in anchoring your dentures or permanent replacements? Y N
13. Are you interested in whitening your teeth? Y N
14. Would you like your smile to look better or different? Describe:

    _____
15. Is there anything we can do to make your visit a more positive experience?_____

    _____
16. Name of previous dentist:_____

I HEREBY AUTHORIZE THE TAKING OF ANY NEEDED X-RAYS OR STUDY MODELS_____

Signature Date

MEDICAL HISTORY

Are you under a physician's care now? Y N If so, why?:

_____

_____

Physicians name: _____

Please list any medications you are currently taking:_____

_____

_____

Do you have any allergies or adverse reactions to any of the following:
(please check box)

- ☐ Aspirin
- ☐ Codeine
- ☐ Erythromycin
- ☐ Local Anesthetic
- ☐ Nitrous Oxide
- ☐ Percodan
- ☐ Penicillin
- ☐ Valium
- ☐ Acrylic
- ☐ Metal
- ☐ Latex

Please list any other allergies you have:_____

_____

WOMEN

Please check if any of the following apply to you:

- ☐ Pregnant or trying
- ☐ Nursing
- ☐ Taking contraceptives

Do you have, or have had any of the following?

(Circle any that apply)

Anaphylaxis	Allergies	Anemia
Angina Pectoris	Arthritis (rheumatism)	Artificial Heart valves
Artificial Joints	Asthma	Atopic (allergy Prone)
Blood disease	Bruise Easily	Cancer
Chemotherapy	Chicken Pox	Diabetes
Dizziness	Drug Addiction	Emphysema
Epilepsy	Excessive Bleeding	Fainting
Food Allergies	Glaucoma	Headaches
Heart Attack	Heart Murmur	Heart Problems
Hemophilia	Hepatitis A,B or C	Herpes
High Blood Pressure	HIV Positive	Jaw Pain
Kidney Disease	Liver disease	Low Blood Pressure
Mitral Valve Prolaspe	M.S.	Nervous Disorders
Pacemaker	Psychiatric treatment	Radiation Treatment
Respiratory Disease	Rheumatic Fever	Scarlet Fever
Shortness of Breath	Sinus Problems	Stomach problems
Stroke	Thyroid Disease	Tobacco Use
Tuberculosis	Ulcers	

FINANCIAL POLICY

FINANCIAL POLICY: We are interested in serving you! Communication and understanding are essential in any professional relationship. Therefore, please make specific financial arrangements with our business office. Thank you. A service charge of 18% per annum is applied to all accounts with balances over 90 days. I acknowledge full responsibility for the payment of such services and agree to pay them in full at the time of service unless other financial arrangements are made in advance. I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I further understand that a collection charge could be added to any overdue balance.

_____

Signature (parent or guardian if minor) Date