DATE_____

NAME_____ HOME PHONE_____

WORK NUMBER_____ CELL PHONE_____

ADDRESS_____

CITY_____ STATE_____ ZIP CODE_____

OCCUPATION_____ SOCIAL SECURITY NO._____

DATE OF BIRTH____/____/____ SEX M F HEIGHT_____ WEIGHT_____

SINGLE_____ MARRIED_____ NAME OF SPOUSE_____

CLOSEST RELATIVE_____ PHONE _____

IF YOU ARE COMPLETING THIS FORM FOR ANOTHER PERSON, WHAT IS YOUR RELATIONSHIP TO THAT PERSON?_____

REFERRED BY_____

For the following questions, circle yes or no, whatever applies? Your answers are for our records only and will be considered confidential. Please note that during your initial visit, you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

1. Are you in good health?.....Yes No

2. Has there been any change in your general health in the past year?.....Yes No

3. My last physical examination was on_____

4. Are you now under the care of a physician?.....Yes No
   If so, what is the condition being treated_____

5. The name and address of my physician (s) is_____
   _____
   _____

6. Have you had any serious illness, operation, or been hospitalized in the past 5 years?
   If so, what was the illness or problem? _____ Yes No

7. Are you taking any medicines including non prescription medicines……Yes No

8. Do you have or have you had any of the following diseases or problems?
   A. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease……..Yes No
   B. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke)……....Yes No
      1. Do you have chest pain upon exertion? Yes No
      2. Are you ever short of breath after mild exercise or when lying down?...Yes No
      3. Do your ankles swell?.....Yes No
      4. Do you have inborn heart defects?.....Yes No
      5. Do you have a cardiac pacemaker?.....Yes No

   C. Allergy.....Yes No
   D. Sinus trouble.....Yes No
   E. Asthma or hay fever.....Yes No
   F. Fainting spells or seizures.....Yes No
   G. Persistent diarrhea or recent weight loss.....Yes No
   H. Diabetes.....Yes No
   I. Hepatitis, Jaundice or liver disease.....Yes No
   J. AID's or HIV infection.....Yes No
   K. Thyroid problems.....Yes No
   L. Respiratory problems, emphysema, bronchitis, etc.....Yes No
   M. Arthritis or painful swollen joints.....Yes No
   N. Stomach ulcer or hyperacidity..... Yes No
   O. Kidney trouble..... Yes No
   P. Tuberculosis..... Yes No
   Q. Persistent cough or cough that produces blood..... Yes No
   R. Persistent swollen glands in neck..... Yes No
   S. Low blood pressure..... Yes No
   T. Sexually transmitted disease..... Yes No
   U. Epilepsy or other neurological disease..... Yes No
   V. Problems with mental health..... Yes No
   W. Cancer..... Yes No
   X. Problems of the immune system..... Yes No
   Y. Any hip or knee replacement.....Yes No

9. Have you had abnormal bleeding?.....Yes No
   A. Have you ever required a blood transfusion?.....Yes No

10. Do you have any blood disorder such as anemia?.....Yes No

11. Have you ever had any treatment for a tumor or growth?..... ...Yes No

12. Are you allergic or have you had a reaction to:

A. Local anesthetics..... .Yes No
B. Penicillin or other antibiotics..... .Yes No
C. Sulfa drugs..... Yes No
D. Barbiturates, sedatives, or sleeping drugs.....Yes No
E. Aspirin..... Yes No
F. Iodine..... Yes No
G. Codeine or other narcotics..... Yes No
H. Other_____

13. Have you had any serious trouble associated with any previous dental treatment .....Yes No
If so, explain_____

14. Do you have any disease, conditions, or problems not listed above that you think I should know about?..... Yes No
If so, explain_____
_____

15. Are you wearing contact lenses?..... Yes No

16. Are you wearing removable appliances?..... Yes No

WOMEN

17. Are you pregnant?.....Yes No

18. Do you have any problems associated with your menstrual period?.....Yes No

19. Are you nursing?.....Yes No

20. Are you taking birth control pills?.....Yes No

Chief Dental Complaint _____

I certify that I have read and understand the above, I acknowledge that my questions, if and, about the inquiries set

forth have been answered to my satisfaction, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in completions of this form.

_____

Signature of Patient

For completion by the dentist.

Comments on patient interview concerning medical history:

_____

_____

_____

Significant findings from questionnaire or oral interview:

_____

_____

_____

Dental management considerations:

_____

_____

_____

Date_____

Medical history update

Date	Comments	Signature
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PATIENT INFORMATION FORM

NEAREST RELATIVE NOT LIVING WITH YOU_____

PHONE_____

LANDLORD_____ PHONE_____

WHOM MAY WE CONTACT IN CASE OF AN EMERGENCY?

_____

WHOM MAY WE THANK FOR REFERRING YOU TO US?

_____

WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL?_____

I WILL BE PAYING TODAY BY:
CASH_____ CHECK_____ CREDIT CARD_____

DENTAL INSURANCE INFORMATION

EMPLOYER_____

INSURED PERSON_____

INSURED ADDRESS_____

INSURED DATE OF BIRTH_____

INSURANCE COMPANY_____

SUBSCRIBER ID (OR SOCIAL SECURITY) NO._____

GROUP NUMBER_____

I understand and agree that, (regardless of my insurance status), ultimately I am responsible for the balance on my account. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information

SIGNATURE_____ DATE_____
PARENT OF GUARDIAN IF ABOVE IS A MINOR_____

PAYMENT POLICY

1. Payment is expected in full at the time of service, unless arrangements have been made.

2. If you have dental Insurance, you are expected to pay the estimated patient portion at the time of service. If there is an over payment you will be promptly issued a check. If there is a balance due you will be billed at the next billing cycle.

3. If needed, we will provide you with a payment plan. A late fee will be added to your bill after **60** days. **(1.5%)**

4. If we do have to bill you, payment is expected within 15 days. If payment or a telephone call is not received in that time, a $20.00 service charge will be added every billing cycle.

5. Any account over 60 days old will be turned over to a collections agency, unless a payment plan has been arranged and signed.

6. A **$30.00** charge per ½ hour will be applied for any appointment canceled or broken without a 24 hour notification.

7. I agree to pay any late fee on any balances of **60 days** or over **1.5%.**

8. I agree to pay all legal fees if I default on my bill and it needs to be settled in court, this includes attorney fees.

9. There is a **20.00** duplicating fee if you need us to send your x-rays to another general dentist office.

10. If this bill is not paid in a timely fashion and is sent to collections and or an attorney, I will be responsible for all collection and/or reasonable attorney fees.

SIGN:_____ DATE:_____

We have been forced to implement this payment policy as part of our continuing effort to keep costs at a minimum to avoid raising our fee schedule.

I the under signed, have read and understand this payment policy.
(please sign and date this form for our records)

SIGNED:_____ DATE:_____

FLUORIDE RINSE

The method we use for cleaning and polishing your teeth is the most effective ever developed by modern dental research. In using this method we're able to remove all of the plaque, calculus, and other harmful debris from your tooth surface. The best time for your teeth to absorb Fluoride is after your tooth surfaces are absolutely clean and polished. This assures you the maximum protection that this mineral affords.

If you have a higher than average adult cavity, dental restoration, or recession of your gums, we will recommend this to you, it is not covered by any insurance plan, the fee is $18.23.

To do this treatment, we administer optimum concentration of two highly effective fluorides, which immediately brings your fluoride protection up to the maximum level. This treatment consists of two one-minute rinses, using the treatment solution, followed immediately by several water rinses to completely remove any fluoride not absorbed by your tooth surfaces. There are no restrictions on eating, drinking or mouth rinsing following this modern treatment.

We strongly recommend that each patient should have this simple, highly effective means of providing maximum fluoride protection.

FLUORIDATED WATER IS USEFUL ONLY IN DEVELOPING (CHILDREN'S) TEETH. TOPICAL FLUORIDE APPLICATIONS IS THE ONLY WAY TO TREAT ERUPTED TEETH.

PLEASE CONSIDER HAVING FLUORIDE TREATMENTS WITH YOUR CLEANINGS. WE LIKE TO INFORM OUR PATIENTS OF THE BEST POSSIBLE HEALTH CHOICES WE HAVE AVAILABLE.

PLEASE CIRCLE YOUR TREATMENT CHOICE:

YES, I PREFER TO HAVE FLUORIDE TREATMENTS WITH MY CLEANINGS

NO, I WISH TO DISREGARD FLUORIDE AT THIS TIME

PLEASE SIGN AND DATE: _____

INSURANCE MAXIMUMS

EVERY YEAR THIS PROBLEM IS COMMON TO SOME OF OUR PATIENTS. FOR A FEW PATIENTS WHO REQUIRE EITHER A LOT OF DENTAL TREATMENT OR HAVE INSURANCE THAT PROVIDES A LESSER TOTAL AMOUNT THAN OTHER THIS BECOMES A PROBLEM.

WE DO OUR BEST TO WATCH INSURANCE AND TO HELP GET AN UNDERSTANDING ON INSURANCE. UNFORTUNATELY EACH EMPLOYER HAS A DIFFERENT POLICY, EVEY INSURANCE COMPANY HAS HUNDREDS OF POLICIES THEY PUT TOGETHER TO SELL, AND SOME LARGER COMPANIES WILL OFFER A MULTITUDE OF DIFFERENT POLICIES TO THEIR EMPLOYER.

WE CANNOT KEEP UP WITH EVERYONE'S INSURANCE MAXIMUMS OR THE EXACT COVERAGE OF EACH POLICY. YOU RECEIVE IN THE MAIL A STATEMENT FROM YOUR INSURANCE COMPANY THAT WILL TELL YOU WHAT YOU HAVE USED AND WHAT YOU HAVE REMAINING. PLEASE LOOK AND BECOME FAMILIAR WITH THIS.

I ALSO CANNOT RECOMMEND TREATMENT BASED SOLELY ON THE TYPE OF INSURANCE COVERAGE YOU HAVE AND I CANNOT RECOMMEND HOLDING OFF ON SOME TREAMENT SOLELY DUE TO YOUR INSURANCE COVERAGE OR MAXIMUMS. IT IS YOUR DECISION TO DO TREATMENT OR HOLD OFF ON RECOMMENDED TREATMENT.

SORRY FOR YET MORE PAPERWORK BUT RECENT SITUATIONS HAVE CAUSED ME TO TAKE THE EXTRA STEP TO MAKE IT CLEAR. AS USUAL WE WILL BE WILLING TO HELP YOU INTERPRET YOUR INSURANCE INFORMATION.

NAME_____
DATE_____

PLEASE BE AWARE THAT WE TRY BUT CANNOT BE RESPONSIBLE FOR KEEPING TRACK OF YOUR INSURANCE COVERAGE OR INSURANCE MAXIMUMS

SIGN AND DATE_____

DR. SUSAN BRACKER

AS A COURTESY TO ALL OUR PATIENTS:

WE WILL BE CONFIRMING ALL APPOINTMENTS

SENDING OUT POSTCARDS TO REMIND PATIENTS OF UPCOMING APPOINTMENTS

HEALTH INSURANCE PRIVACY PROTECTION ACT (HIPPA)

I have been given the Health Insurance Privacy Protection Act (HIPPA) information. I have been given the opportunity to ask questions and signed a copy, which I am to take home.

SIGNATURE_____
DATE_____

DENTAL HISTORY

1. Date of last dental visit, name of dentist, and what you were seen for. If for an emergency please describe.

DENTIST_____
DATE_____
DESCRIBE TREATMENT_____
_____

2. Date of last dental cleaning and dame of dentist.

DENTIST_____
DATE_____

3. How long have you been seeing the above dentist?

4. If you have been seeing the above dentist less than 1 years list the past dentists you have seen and number of years treated.

5. Have you been going for regular cleanings every 6 months?

YES NO

6. If you have not been going to the dentist for regular cleaning please explain why.

7. Please explain why you have left your previous dentist (details required)

8. Date of your last dental x-rays and what office were they taken at?

9. Have you asked to have your x-rays forwarded to my office?

YES NO

10. Have you had orthodontics (braces)? **YES NO**

If yes Dentist name and age of treatment

11. Have you been recommended to have orthodontic treatment and decided not to?
YES NO
Please explain why you decided not to have treatment.

12. Have you had your wisdom teeth removed? **YES NO**
If yes Dentist name and age of treatment

13. Have you ever been informed you had gum disease or gingivitis? **YES NO**
If you have been informed what was done for treatment and name of dentist who informed you.

14. Have you ever been referred to a gum specialist (periodontist)? **YES NO**

15. If yes please state name of specialist who treated you:

If yes but you decided not to be treated please state why

16. Do you know what TMJ is? **YES NO**.

17. Have you ever been made aware or suspected that you have symptoms of TMJ?
YES NO
Have you ever experienced any of the following symptoms (please circle)

Frequent headaches	Pain near your ears
Jaw stuck open	Jaw stuck closed
Pain on opening	Pain on closing
Wake up with tired jaw	Clench your teeth
Grind your teeth	Cheek muscles sore to touch
Unable to open your mouth all the way	ear pain
Jaw pop or click when opening or closing	

If yes to any of the above please write details on back of sheet, include how frequent, if this happened in the past or do you still have the symptoms.

18. If you have been treated for TMJ please state name of dentist or other health professional and type of treatment received:

19. Have you ever been told you have TMJ and decided not to have treatment?
YES NO

20. Do you presently Smoke? **YES NO**
How many packs do you smoke daily?
How long have you been smoking?

21. Have you smoked in the past? **YES NO**
How many days, months, or years have you stopped smoking?
How many packs a day did you smoke?

22. Do you currently or have you ever used chewing tobacco or snuff? **YES NO**
If yes please describe frequency and number of years.

23. Has any family member ever had oral cancer? **YES NO**

24. Do you drink alcoholic beverages? **YES NO**
If yes please list types of drinks and how often.

25. Do you drink Soda/Juice/Sports drinks? **YES NO**
If yes please describe type and frequency.

26. Do you drink sugar with your coffee or tea? **YES NO**

27. Please describe the amount of candy or other sweets you eat.

28. Are you happy with the appearance of your teeth? **YES NO**
If no please tell me what you would like to change.

29. Have you ever whitened your teeth? **YES NO**
If yes tell me types of products you used.

30. How often do you brush your teeth?
Type of toothpaste you use?

31. How often do you floss?

32. Do you brush your tongue?

33. How did you hear about our office?

BISPHOSPHONATE MEDICATIONS

These medications are used to treat multiple myeloma or metastatic bone cancer associated with breast, lung, and prostate cancer. Many patients taking these medications are spared several years of debilitating bone pain or fractures that go along with these diseases.

Unfortunately a small percentage of patients will be trading the bone destruction and pain associated with their disease for bisphosphonate related osteonecrosis of the jaw bones (simply put can cause the bone in the jaws to die.) This could happen without dental treatment but is a great complication with tooth extractions.

Complications of this type are more common with patients treated by IV. Patients treated with oral medications have rare complications but the risk is still there.

REVIEW THE LIST OF MEDICATIONS BELOW:

>Pamidronate (APD< Aredia)-100
>Neridronate-100
>Olpadronate-500
>Alendronate (Fosamax)-500
>Ibandronate (Bondronate)-1000
>Risedronate (Actonel)-2000
>Zoledronate (Zometa)-10000
>Etidronate (Didronel)-1 (potency relative to that of etidronate)
>Clodronate (Bonefos, Loron)-10
>Tiludronate (Skelid)-10

If you are unsure if you have taken any of these please call your physician immediately and ask.

CIRCLE ONE OF THE BELOW:

YES I have taken one of the above, please circle the medication you have taken.

NO I have not ever taken any of the above medications

I am unsure, and will call my physician

SIGN AND DATE_____

EMERGENCY PATIENTS

PLEASE READ AND SIGN:

My policy is to see my patients the same day or the next when you call for any dental emergency. However, I am attempting to fit you in-between patients with scheduled appointments. Patients with scheduled appointments get very upset when their appointment is delayed. You may be required to wait for complete treatment. I will make every effort to relieve your pain as quickly as possible.

SIGN_____

DATE_____

APPOINTMENTS AFTER 4 PM

Please be aware that if due to your schedule you may only have an appointment after 4pm, we do have a tendency to run behind. A large percentage of patients have the same needs. If time is truly of the essence inform us when you check in and we will let you know how the schedule is running. If it is at all possible please try to schedule an appointment at an earlier time.

SIGN _____

DATE_____

Thank you,

Dr. Susan Bracker

PATIENTS WHO SUFFER FROM DENTAL ANXIETY

If you feel that you have **greater than average anxiety** about coming to the dentist we ask that you please schedule your appointments in the morning or no later than 2:00 in the afternoon. After 3:30 we get very busy and find it difficult to give the extra loving care and time that you require.

If you feel you **have severe anxiety** we do offer **sedation dentistry** to make your appointment more pleasant. You will need to have a ride and your appointment must be scheduled in the morning or early afternoon .

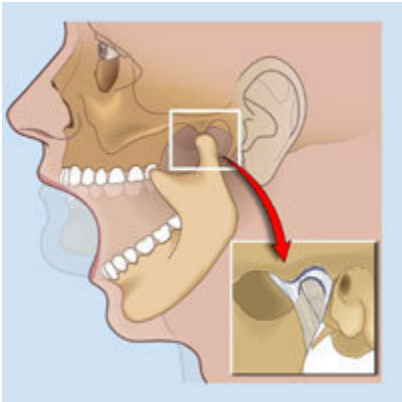
SIGN_____

DATE_____

Information about TMJ

TMJ is the joint that joins the skull and the lower jaw. It is used hundreds of times each day. **A small disc of cartilage separates the bone, much like the knee joint, so the lower (mandible)** may slide more freely. Every time you talk, swallow, or eat this joint is used.

How can things go wrong with TMJ?



The Cartilage disc between the bones can wear, or stretch . This can result in the feeling of pressure in the area or sounds of popping and clicking when you open or close your mouth. Also chewing muscles may spasm. Previous major or minor trauma can contribute even if at the time it is not apparent.

During dental treatment having your mouth open extended periods of the may result in soreness of this joint or muscle spasms. On the rare occasion a joint that may not have had any apparent symptoms in the past can cause symptoms to start. Should you develop any symptoms you need to contact the office and we will inform you of what to do to help relieve those symptoms. During dental treatment on occasion your jaw may lock open, we will manipulate your jaw closed and advise you of what to expect.

_____**SIGN AND DATE**

Please inform me of any previous problems you may have had – write details below-

_____

_____

_____

_____

_____

_____