Siegert DENTAL FAMILY, COSMETIC, ORTHO, IMPLANTS, & TMJ

We would like to get to know you better

It is important that we know your Medical and Dental History. These facts have a direct bearing on your Dental health. This information is strictly confidential and will not be released to anyone.

Name_____ Date of Birth_____

Address_____ Home Phone_____

_____ Cell Phone_____

Email_____

May we have your permission to contact you via email/ Cell phone? _____

Name of Employer _____ Work Phone_____

May we contact you at work? _____

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

In case of Emergency, please notify_____ Phone_____

Peron responsible for this account (if other than self)

Name_____

Address_____

_____

(City) (State) (Zip)

Are you covered by a Dental Plan as a benefit of your employer? _____

Please provide administrative team a copy of the Benefit Card and we will file any necessary claims as courtesy

Why did you leave your last dentist?

_____

Is there anything we should know to ensure your comfort?

_____

Siegert Dental Medical History

Are you under a physician's care now?	Yes ◯ No ◯	If Yes _____
Have you ever been hospitalized or recently had surgery?	Yes ◯ No ◯	If Yes _____
Have you taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?	Yes ◯ No ◯	If Yes _____
Are you on a special diet?	Yes ◯ No ◯	If Yes _____
Do you use tobacco?	Yes ◯ No ◯	If Yes _____
Do you use controlled substances?	Yes ◯ No ◯	If Yes _____
Do you have any artificial joint replacements?	Yes ◯ No ◯	If Yes _____
Any trouble associated with previous dental treatment?	Yes ◯ No ◯	If Yes _____

Women: Are you... ◯ Pregnant/ trying to get pregnant ◯ Nursing ◯ Taking Oral Contraceptives

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

Anemia	Yes O No O	Angina	Yes O No O	Asthma	Yes O No O
Blood Disease	Yes O No O	Artificial heart Valve	Yes O No O	Breathing Problems	Yes O No O
Blood Transfusion	Yes O No O	Chest pains	Yes O No O	Emphysema	Yes O No O
Bruise Easily	Yes O No O	Congenital Heart Disease	Yes O No O	Lung Disease	Yes O No O
Excessive Bleeding	Yes O No O	Heart Attack/ Failure	Yes O No O	Liver Disease	Yes O No O
Hemophilia	Yes O No O	Heart Murmur	Yes O No O	Thyroid Disease	Yes O No O
High Blood Pressure	Yes O No O	Heart Pacemaker	Yes O No O	Parathyroid Disease	Yes O No O
Low Blood Pressure	Yes O No O	Heart Trouble. Disease	Yes O No O	Glaucoma	Yes O No O
Anaphylaxis	Yes O No O	Mitral Valve Prolapse	Yes O No O	Hay Fever	Yes O No O
Alzheimer's disease	Yes O No O	Irregular Heartbeat	Yes O No O	Hives or Rash	Yes O No O
AIDS/ HIV Positive	Yes O No O	Stroke	Yes O No O	High Cholesterol	Yes O No O
Venereal Disease	Yes O No O	Convulsions	Yes O No O	Kidney Problems	Yes O No O
Cold Sores/ Fever Blisters	Yes O No O	Fainting Spells/ Dizziness	Yes O No O	Diabetes	Yes O No O
Hepatitis A	Yes O No O	Drug Addictions	Yes O No O	Cancer	Yes O No O
Hepatitis B or C	Yes O No O	Cortisone Medicine	Yes O No O	Chemotherapy	Yes O No O
Herpes	Yes O No O	Osteoporosis	Yes O No O	Leukemia	Yes O No O
Sinus troubles	Yes O No O	Spina Bifida	Yes O No O	Radiation treatments	Yes O No O
Ulcers	Yes O No O	Renal Dialysis	Yes O No O	Tumor or Growth	Yes O No O
Shingles	Yes O No O	Rheumatic Fever	Yes O No O	Unexplained weight loss	Yes O No O
Sickles Cell Disease	Yes O No O	Rheumatism	Yes O No O	Scarlet Fever	Yes O No O
Psychiatric Care	Yes O No O	Tuberculosis	Yes O No O	Stomach/ Intestinal disease	Yes O No O

Have you ever had any serious illnesses not listed above? _____

Are you allergic to any of the following?

◯ Aspirin ◯ Penicillin ◯ Codeine ◯ Acrylics ◯ Barbiturates/ Sedatives/Sleeping Pills
◯ Metal ◯ Latex ◯ Sulfa Drugs ◯ Local Anesthetics ◯ Iodine
◯ Other _____

Please list any medications you are currently taking: _____

_____

_____ _____

Patient or Guardian Signature **Date**

Dental History and Health Questionnaire

How long since your last thorough exam and full mouth set of x-rays? _____
Have you had an upsetting experience in a dental office? _____
What's prompted you to seek Dental Care at this time? _____
Is there a fear of discomfort that's kept you from regular dental visits? _____
Is there anything other than finances that would influence you in your decision to move forward with treatment?
_____

Past Dental treatment

Oral Surgery	Y	N
Orthodontics (Braces)	Y	N
Periodontal/ Gum	Y	N

Do you supplement with fluoride?	Y	N
Do you notice any loose/mobile teeth?	Y	N
Is food constantly caught between teeth?	Y	N
Any unpleasant taste or odor in your mouth?	Y	N

If you've had your wisdom teeth or others removed, how long have these teeth been missing? _____

Are you dissatisfied with the looks of your teeth? For example Color, Shape, Spaces, Ect?_____
_____

Have you experienced lumps or sores in or around your mouth? Please explain:
_____

Pain Symptoms

Do you get headaches?	Y	N
Do you get Migraine Headaches?	Y	N
Chronic back/ shoulder pain?	Y	N
Do you awaken with sore teeth?	Y	N

Where are your headaches located? _____
_____

Do you have troubles sleeping soundly?	Y	N
Do you clench/grind your teeth at night?	Y	N
Do you clench your teeth during the day?	Y	N
Are your jaws tired when you awaken?	Y	N

When are your symptoms worse? _____
_____

Does anything make you feel better? _____
_____

How often do you take medication for relief of pain?
_____

Trauma or Accident

Have you ever been involved in any serious accident, such as a car accident? Y N
Details_____

Jaw Joint Symptoms

Does your jaw get tired easily?	Y	N
Do avoid chewing certain foods?	Y	N
Do you ever get dizzy?	Y	N
Do you ever feel faint?	Y	N
Difficulty/pain opening wide?	Y	N

Have you experienced 'clicking' 'popping' or cracking noise from either jaw joint?	Y	N
Has your jaw ever locked open or closed?	Y	N
Any family history of jaw joint(TMJ) problems or headaches?	Y	N

Breathing

Do you have allergies?	Y	N
Do you snore at night?	Y	N

Have you been diagnosed with Sleep Apnea?	Y	N
Have you had a sleep study done?	Y	N

SIGNATURE_____ DATE_____

Siegert Dental

Office Policy

Our practice believes in the theories of modern dental care. Through proper preventive care and regular checkups, it's highly likely that most of our patients can expect to keep their teeth for all of their lives. We realize everyone's personal financial situation is different. For this reason we have worked hard to provide a variety of payment options to help you receive the dental care needed in order to enjoy a healthy and confident smile.

Dental Insurance

Our doctors present the most effective treatment plans to ensure optimal oral health; their clinical recommendations are not based on insurance benefits. Most policies will cover the least expensive course of treatment, when more than one treatment option exists. Our doctors and patient care coordinators will do their best to advise you of your treatment options, if you are not familiar with each individual insurance policy. It is the patient's responsibility to understand their policy and the charges for treatments not covered by insurance company's fee allowance.

As a courtesy, we will file the forms necessary for the dental services provided, but the patient is responsible for providing the complete and accurate insurance information to our office in a timely manner. We can provide you an estimate of what your insurance may cover. Your estimated percentage is due on the day of service. We encourage all patients to contact their insurance company to verify policy coverage information, as the patient is ultimately responsible for understanding his/her own policy. If there are any questions about coverage we encourage patient to request a pre authorization with the insurance that we can also file as courtesy.

Treatment

By Scheduling an appointment, I am consenting to the treatment that will be provided during the appointment, including anesthetic as needed. I have had the opportunity to discuss benefits and am making an informed decision.
I understand that treatment recommendations are based on information collected by the dentist and staff during the course of an examination; that may include periodontal charting (gums measurements) and radiographs (x-rays). In order for proper diagnosis, perio charting and radiographs are required periodically, per my doctor's recommendation. If I choose to deny this, I understand that I can be asked to sign a records transfer and seek care at another office.

Emergencies - I consent to any procedure deemed necessary for my well-being, should an emergency arise during the course of the appointment.

Returned Check policy - There is a $25 fee per check that is returned to us.

Phone Consent - I understand /consent to receiving calls or messages regarding an outstanding balance on my account, or a co-pay that is due at the time of treatment.

Missed Appointment Policy

At our office we know that your time is valuable and we make sure that the time we reserve for you is yours to keep. We understand that unforeseen situations arise, upon which you must cancel your appointment. **It is therefore requested that if you must cancel or reschedule your appointment, you provide a minimum of24 hours' notice**. This will allow us to accommodate guests that are currently on a waiting list. Please also be advised that if you should arrive more than ten (10) minuets past your scheduled appointment time, your appointment may need to be reschedule to accommodate our time commitments to our other guests. We ask that you provide us with any changes in your telephone number; if we are unable to reach you within 48 hours to confirm your appointment we have the right to move the appointment time to accommodate another guest.

Guests who do not show up for their appointment without a call to cancel an appointment or procedure will be considered a NO SHOW. **Guests who No-Show two (2) times will be charged a $100 missed appointment fee. Guests who No-Show three (3) or more times in a 12 month period, may be dismissed from the practice** thus they will be denied any future appointments unless they should opt to pay a $200 inconvenience fee.

I understand that payment is my obligation regardless of insurance or any third party involvement. I have read and agree to the office polices of Siegert Dental. I understand that failure to sign these policies may result in my dismissal from Siegert Dental.

Signature_____ Date_____