REICHEL DENTAL

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Welcome to our practice. The benefits of a healthy, beautiful smile are immeasurable and our goal is to allow you to obtain the healthy teeth and attractive smile you want and deserve. Please complete this form so that we can provide the best care possible for you.

About You

First Name_____ MI _____ Last Name_____
I Like to be Called _____ SS#_____
Home Address _____
City _____ State _____ ZIP_____
Employer _____ Occupation_____
Special Interests or Hobbies _____
Date of Birth _____ Your Age Today _____
Whom can we thank for referring you? _____
Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Reaching You

Home Phone_____ Work Phone _____ Cell Phone _____
E-mail_____
How do you prefer we reach you? _____ When is the best time to call? _____

Emergency Contact

Name _____
Home Phone_____Cell Phone_____ Relationship to You _____

Medical History

Name of Primary Care Physician _____
Name of Medical Practice _____
Phone Number _____ Date of Last Visit _____

Your Current Health: ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Are you current under doctor's care? ❑ No ❑ Yes If yes, please describe: _____
_____

Have you ever had a blood transfusion? ❑ No ❑ Yes If yes, please give approximate date(s) _____

_____
Have you had any serious medical problems or operations within the past 10 years? ❑ No ❑ Yes

If yes, please explain: _____

Medical History (cont.)

Please check if you have ever been treated for any of the following diseases or medical conditions:

- ❑ AIDS/HIV Positive
- ❑ Acid Reflux
- ❑ Anaphylaxia
- ❑ Anemia
- ❑ Arthritis/Rheumatism
- ❑ Artificial Heart Valves
- ❑ Asthma
- ❑ Atopic (Allergy Prone)
- ❑ Back Problems
- ❑ Cancer
- ❑ Chemical Dependency (Drug/Alcohol)
- ❑ Chemotherapy
- ❑ Circulatory Problems
- ❑ Cortisone Treatments
- ❑ Cough (Persistetnt)
- ❑ Cough up Blood
- ❑ Diabetes
- ❑ Eating Disorder
- ❑ Epilepsy/Seizures
- ❑ Fainting
- ❑ Food Allergies
- ❑ Glaucoma
- ❑ Headaches
- ❑ Heart Murmur
- ❑ Heart Attack
- ❑ Heart Problems

Please Describe: _____

_____

_____

- ❑ Hemophilia
- ❑ Abnormal Bleeding
- ❑ Herpes
- ❑ Hepatitis
- ❑ Jaundice
- ❑ High Blood Pressure
- ❑ Jaw Pain
- ❑ Kidney Disease or Malfunction
- ❑ Material Allergies (Latex, Wool, Metal, Chemicals)
- ❑ Mitral Valve Prolapse
- ❑ Nervous Problems
- ❑ Psychiatric Care
- ❑ Rapid Weight Gain
- ❑ Rapid Weight Loss
- ❑ Radiation Treatment
- ❑ Respiratory Disease
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Shingles
- ❑ Shortness of Breath
- ❑ Skin Rash
- ❑ Spina Bifida
- ❑ Stroke
- ❑ Surgical Implant
- ❑ Swelling of Feet
- ❑ Swelling of Ankles
- ❑ Thryoid Disease or Malfunction
- ❑ Tobacco Habit
- ❑ Tonsilitis
- ❑ Tuberculosis
- ❑ Ulcer/Colitis
- ❑ Veneral Disease

Have you ever been treated for any other illness not listed above? ❑ No ❑ Yes

If yes, please explain _____

_____

Do you need to be pre-medicated before dental treatment? ❑ No ❑ Yes ❑ Don't Know

Are you allergic to any of the following medications?

Aspirin: ❑ No ❑ Yes Codeine: ❑ No ❑ Yes Dental Anesthetic/Novocaine: ❑ No ❑ Yes

Erythromycin: ❑ No ❑ Yes Penicilin: ❑ No ❑ Yes

Are you allergic to any other medications? ❑ No ❑ Yes

If yes, please explain: _____

_____

Are you currently taking any prescription, over the counter medications, or supplements? ❑ No ❑ Yes

Name of Medication_____ Purpose_____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Do you smoke? ❑ No ❑ Yes If yes, how much per day? _____

Do you you use chewing tobacco? ❑ No ❑ Yes If yes, how much per day? _____

For Women

Are you pregnant? ❑ No ❑ Yes If yes, when are you due? _____

Are you currently nursing? ❑ No ❑ Yes

Are you currently on birth control? ❑ No ❑ Yes

Dental History

Why have you come to Dr. Reichel's office today? _____

Are you currently in pain or discomfort with your teeth? ❑ No ❑ Yes Your gums? ❑ No ❑ Yes
If yes, please explain _____

How would you rate the condition of your teeth? (worst) 1 2 3 4 5 6 7 8 9 10 (best)
How would you rate the condition of your gums? (worst) 1 2 3 4 5 6 7 8 9 10 (best)
How important is it to you to keep your teeth and gums as healthy as possible? (not at all) 1 2 3 4 5 6 7 8 9 10 (very)

Date of your last dental visit: _____ Date of your last dental x-rays: _____

If you could wave a magic wand and change anything about the appearance of your smile, what would you want to do? _____
_____

If you could safely and easily whiten your teeth, would you be interested? ❑ No ❑ Yes

How often do you brush your teeth? _____ How often do you floss your teeth? _____

What type of toothbrush do you use? ❑ Manual ❑ Soft ❑ Medium ❑ Hard
❑ Power/Battery Operated What brand? _____

Do your gums bleed when you brush? ❑ No ❑ Yes Do your gums bleed when you floss? ❑ No ❑ Yes

Have you ever had tooth brushing and flossing intstruction? ❑ No ❑ Yes

Please check if you have had problems or been treated for any of the following:

❑ Bad Breath	❑ Broken Fillings	❑ Sores or Growths in or Around Mouth
❑ Red, Swollen or Bleeding Gums	❑ Periodontal (Gum) Treatment	❑ Dry Mouth
❑ Clicking or Popping Jaw	❑ Sensitivity to Cold	❑ Orthodontics (Braces)
❑ Food Collecting Between Teeth	❑ Sensitivity to Hot	❑ Root Canal Treatment
❑ Loose Teeth	❑ Sensitivity to Sweet	❑ Extractions
❑ Lost Fillings	❑ Sensitivity when Biting	❑ Stained Teeth

❑ Have you ever been told you grind your teeth? When? _____
❑ Have you ever been told you clench your teeth? When? _____
❑ Have you ever been told you snore? _____

Have you ever experienced pain in your jaw joint? ❑ No ❑ Yes
Have you ever been treated for TMJ symptoms? ❑ No ❑ Yes
If yes, please explain: _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ❑ No ❑ Yes
If yes, please explain: _____

Is there any other information about your dental health or previous treatment you feel we should know about? _____
_____
_____
_____

Dental Benefit Information

Primary Insurance Coverage

Subscriber Last Name_____ First _____ MI _____
Relationship to Patient _____
Date of Birth _____ SS# _____
Address (if different from patient) _____
Home Phone _____City _____ State _____ ZIP _____
Subscriber Employed By _____ Occupation _____
Business Address _____ Business Phone _____
Insurance Company Phone #_____
Contract #_____Group # _____Subscriber # _____
Name of Other Dependents Under this Plan _____
_____

Secondary Insurance Coverage

Subscriber Last Name_____ First _____ MI _____
Relationship to Patient _____
Date of Birth _____ SS# _____
Address (if different from patient) _____
Home Phone _____City _____ State _____ ZIP _____
Subscriber Employed By _____ Occupation _____
Business Address _____ Business Phone _____
Insurance Company Phone #_____
Contract #_____Group # _____Subscriber # _____
Name of Other Dependents Under this Plan _____
_____

Authorization

I have reviewed this information in this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by Dr. Reichel to help determine appropriate and healthful dental treatment. Additionally, I understand this information will be held in the strictest of confidence and will only be used to improve communication between Dr. Reichel and me.
If there are any changes in my medical status, I will inform Dr. Reichel.

I authorize the insurance company indicated on this form to pay to Dr. Reichel all insurance benefits otherwise payable to me for the services rendered. I authorize the use of this signature on all insurance submissions.

I authorize Dr. Reichel to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment, unless prior arrangements have been approved.