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: ______

____

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- ❑ 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 prescription medications? ❑ No ❑ Yes If yes, please list below:

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

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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.