

GETTING TO KNOW YOU

Patient Information

Last _____ First _____ Middle Initial _____
Preferred Name: _____ Gender: Male/Female Birthday: Month ____ Day ____ Year ____
Social Security # _____ Driver's License # _____ State _____
Home Phone # () _____ - _____ Cell Phone # () _____ - _____
Email: _____
Street Address _____ City _____ Zip Code _____
Mailing Address (if different from street address) _____
Nearest Relative (not living with you) _____ Relationship: _____
Street Address _____ City _____ Zip Code _____
Contact Phone # () _____ - _____
Occupation: _____ Employer: _____
Employer Address: _____
Work Phone# () _____ - _____
Who may we thank for referring you to us? _____

Spouse, Parent or Guardian Information

Last _____ First _____ Middle Initial _____
Street Address _____ City _____ Zip Code _____
Contact Phone # () _____ - _____

(We require all persons under the age of 18 years old be accompanied by a guardian or parent.

Signature: _____ Date: _____

DENTAL INSURANCE INFORMATION

We are happy to process your insurance claims complimentary to maximize your benefits. Since insurance can be confusing, we ask that you call or contact us with specific questions. Because insurance policies vary, we can only estimate your coverage in good faith but cannot guarantee coverage due to the complexities of insurance contracts. As a service to our patients, we will bill insurance companies for services and allow them 45 days to render payment. After 45 days, you are responsible for the entire balance, paid-in-full. If you have any questions, our courteous staff is always available to answer them.

Primary Insurance Information:

Dental Insurance Carrier _____ Group # _____

Name of the Insured: _____ Member I.D.# _____

Social Security # of Insured: _____ Birthday: Month ____ Day ____ Year ____

Relationship to Insured: Self / Spouse / Child / Other _____

Employer of Insured: _____ Contact # of Insured: () ____ - ____

Secondary Insurance Information:

Dental Insurance Carrier _____ Group # _____

Name of the Insured: _____ Member I.D.# _____

Social Security # of Insured: _____ Birthday: Month ____ Day ____ Year ____

Relationship to Insured: Self / Spouse / Child / Other _____

Employer of Insured: _____ Contact # of Insured: () ____ - ____

We will only file primary and secondary insurance. If you have a third insurance or a cafeteria Plan or HSA, you will need to be responsible for filing with those agencies. We will be happy to provide you with copies of any information you may need to file these documents for reimbursement.

Coffee Creek Family Dentistry is a Provider for Delta Dental Premier and United Concordia.
We can file all other dental insurance for you as Out-of-Network.

Signature: _____ Date: _____

PATIENT HEALTH QUESTIONNAIRE

PATIENT NAME: _____ **DATE:** _____

What is your reason for today's visit? _____
 How long has this been bothering you? _____

Who referred you to us? _____
 Name of physician: _____ Phone Number: _____

Medical History

Have you been examined by a physician within the last five years? If so, when? _____ Yes No

Are you presently being treated by a physician for any condition? Yes No

If so, for what condition(s)? _____

Are you taking any prescription or non-prescription medications at this time, or have you within the Last 6 weeks? If so, what are they? _____ Yes No

Do you take an aspirin daily? If so, why? _____ Yes No

Are you ALLERGIC to any of the following medications or materials?

Penicillin	Yes	No	Sulfa Drugs	Yes	No	Erythromycin	Yes	No	Tetracycline	Yes	No	
Aspirin	Yes	No	Codeine	Yes	No	Dental Anesthetic	Yes	No	Other Medicine	Yes	No	_____
Acrylic	Yes	No	Latex	Yes	No	Metals	Yes	No	Other Materials	Yes	No	_____

Have you ever had, and/or been treated for, any of the following conditions?

Heart Attack	Yes	No	Bleed/Bruise Easily	Yes	No	Kidney Disease	Yes	No	Seizures	Yes	No
Heart Murmur	Yes	No	Breathing Problems	Yes	No	Liver disease	Yes	No	Dizziness/Fainting	Yes	No
Mitral Valve Prolapse	Yes	No	Lung Disease	Yes	No	Jaundice	Yes	No	Nervousness	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No	Hepatitis	Yes	No	Psychiatric Care	Yes	No
Artificial Heart Valve	Yes	No	Seasonal Allergies	Yes	No	Arthritis	Yes	No	Chemotherapy	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Artificial Joints	Yes	No	Radiation Therapy	Yes	No
Heart Disease	Yes	No	Thyroid Disease	Yes	No	Ulcers	Yes	No	Blood Transfusion	Yes	No
Swelling of Limbs	Yes	No	Excessive Thirst	Yes	No	Eating Disorders	Yes	No	Drug Addiction	Yes	No
High Blood Pressure	Yes	No	Hypoglycemia	Yes	No	GI Disorders	Yes	No	HIV / AIDS	Yes	No
Low Blood Pressure	Yes	No	Diabetes	Yes	No	Stroke	Yes	No	Syphilis / Herpes	Yes	No

Have you ever been treated for a tumor, cyst, or any type of cancer? If so, what type and when? _____ Yes No

Have you ever been seriously ill or hospitalized? If so, what was the condition, and when? _____ Yes No

Please list any other diseases or conditions that you have been treated for: _____

Do you have a family history of any of the conditions listed or mentioned above? If so, which ones? _____ Yes No

Please answer the following questions:

Are you on a special diet, or diet medication? If so, which type and for how long? _____ Yes No

Do you smoke? If so, how much do you smoke per day? _____ Yes No

Do you use any form of smokeless tobacco? If so, what, and how much do you use it? _____ Yes No

Do you use alcoholic beverages? If so, how often? _____ Yes No

Women (please check if applicable): ___Pregnant or trying to become pregnant ___Nursing ___Using Birth Control Pills

I certify that to the best of my knowledge, the above information is complete and correct.

Patient Signature (Parent or Guardian) _____ **Date:** _____

History Reviewed by (Doctor) _____ **Date:** _____

PATIENT DENTAL QUESTIONNAIRE

PATIENT NAME: _____ DATE: _____

Dental History

How long has it been since your last dental examination? _____ Since your last dental cleaning? _____

Are you apprehensive about receiving dental treatment? Yes No

For Children (please check all that apply): ___First dental visit ___Relaxed ___Nervous___Bad previous experience

Are you unhappy with your smile? Yes No

Is there anything you would like to change about your smile? If so, what would that be? Yes No

Do you have a specific dental concern? If so, what is it? _____ Yes No

Do you have any broken teeth? Yes No

Are you missing any teeth? Yes No

Do you have any teeth that are sensitive to biting and chewing? Yes No

Do you think that you might have any tooth decay? Yes No

Do you have any areas that trap food between the teeth? Yes No

Do have any loose teeth? Yes No

Do you have any bleeding, swelling, or soreness in your gums? Yes No

Have you ever been diagnosed with periodontal disease? If so, how long ago? _____ Yes No

Do you clench or grind your teeth? Yes No

Do you have any problems with your jaw joints, such as pain, popping/clicking, or limited opening? Yes No

Does your jaw ever get stuck in the open position? Yes No

Does chewing or yawning ever cause pain? Yes No

Do you ever have pain in or near your ears or cheeks? Yes No

Have you ever been treated for TMJ problems? Yes No

Do you currently wear dentures or partial dentures? If so, how old are they? _____ Yes No

If so, please mark which you have? ___Upper Denture ___Lower Denture ___Upper Partial ___Lower Partial

If you wear dentures or partial dentures, is there anything that you would like change about them? Yes No

If so, what is it? _____

If you wear dentures or partials, or have any missing teeth, would you like to learn more about implants? Yes No

Do you use a mouthwash regularly? If so, which one? _____ Yes No

Which toothpaste do you use the most? _____

How often do you brush your teeth? _____

How often do you floss? _____

Do you use a fluoride supplement or rinse on a regular basis? If so, which one? _____ Yes No

I certify that to the best of my knowledge, the above information is complete and correct.

Patient Signature (Parent or Guardian) _____ Date: _____

History Reviewed by (Doctor) _____ Date: _____