Patient Information

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

Last Name _____First Name _____ Nick Name_____

Home Address_____

Cell Phone _____ Home Phone _____ Work Phone_____

DOB ____/____/____ Marital Status _____ SS#_____

SEX M ☐ F ☐ E-Mail Address _____

Emergency contact _____ Phone number_____

For Minors
Mother's Name _____Father's Name _____

PRIMARY INSURANCE COVERAGE

Insurance Company _____

Subscriber Name_____ Subscriber ID or SS Number_____

Relationship to Patient _____ Subscriber DOB ____/____/____

Group Name _____ Group Number_____

SECONDARY INSURANCE COVERAGE

Insurance Company_____

Subscriber Name _____ Subscriber ID or SS Number_____

Relationship to Patient _____ Subscriber DOB _____/_____/_____

Group Name _____Group Number_____

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA and the ADA.

Cancellation Policy: Last minute cancellations deny other patients the benefit of treatment they need. I understand that regular charges may be applied for missed appointments without 24-business hour advance cancellation notice. I understand that my insurance carrier will not pay for my absence and I will be responsible for these charges.
Fee for a missed appointment is $35 per ½ hour.

I hereby authorize payment by my insurance company to ***Mark R. Koenen, D.D.S.*** I authorize this office to release any information necessary to expedite the payment of insurance claims. I understand that I am responsible for all charges and balances, regardless of insurance coverage. I understand that I am responsible for all co-payment amounts at the time of service.

_____

Signature (Self or Parent/Guardian) Date

Confidential Health History Form Today's Date_____

Patient Name: First_____ MI__Last_____ Date of Birth_____

I. Circle appropriate answer *(Leave blank if you do not understand the question)*

☐Yes ☐No Is your general health good? if No, explain_____
☐Yes ☐No Has there been any change in your health within the last year? If Yes, explain_____
☐Yes ☐No Have you gone to the hospital or emergency room or had a serious illness in the last three years? if Yes, explain_____
☐Yes ☐No Are you currently undergoing medical treatment? if Yes, explain_____M.D.'s name:_____ph. #:_____
☐Yes ☐No Are you in pain now? if Yes, explain_____

II. Have you experienced any of the following? *(Please circle Yes or No for each)*

☐Yes ☐No Chest pain (angina)	☐Yes ☐No Frequent headaches	☐Yes ☐No Shortness of breath
☐Yes ☐No Fainting spells/dizziness	☐Yes ☐No Bruising easily	☐Yes ☐No Sinus problems
☐Yes ☐No Recent significant weight loss	☐Yes ☐No Excessive thirst	☐Yes ☐No Hearing trouble
☐Yes ☐No Bleeding problems	☐Yes ☐No Joint pain or stiffness	☐Yes ☐No Snoring

III. Have you had or do you have any of the following? *(Please circle Yes or No for each)*

☐Yes ☐No Heart disease	☐Yes ☐No Cancer type:_____ year: _____	☐Yes ☐No Kidney problems
☐Yes ☐No Heart attack date:	☐Yes ☐No Radiation treatment	☐Yes ☐No Liver disease
☐Yes ☐No Heart defects	☐Yes ☐No Chemotherapy	☐Yes ☐No Jaundice
☐Yes ☐No Heart murmur	☐Yes ☐No Tumors or growths	☐Yes ☐No Anaphylaxis
☐Yes ☐No Irregular heartbeat	☐Yes ☐No Skin disease	☐Yes ☐No Sleep apnea
☐Yes ☐No Artificial heart valve/pacemaker	☐Yes ☐No Stomach or intestinal disease	☐Yes ☐No Transplants
☐Yes ☐No Artificial joint joint: _____ date: ____	☐Yes ☐No Ulcers	☐Yes ☐No Hepatitis A B C
☐Yes ☐No High blood pressure	☐Yes ☐No Emphysema or other lung disease	☐Yes ☐No Herpes
☐Yes ☐No Low blood pressure	☐Yes ☐No Asthma carry an inhaler? ☐Yes ☐No	☐Yes ☐No Shingles
☐Yes ☐No Acid reflux	☐Yes ☐No Arthritis, gout	☐Yes ☐No AIDS/HIV
☐Yes ☐No High cholesterol	☐Yes ☐No Rheumatism	☐Yes ☐No Tuberculosis
☐Yes ☐No Blood disorder	☐Yes ☐No Thyroid disease	☐Yes ☐No Cosmetic surgery
☐Yes ☐No Leukemia	☐Yes ☐No Stroke	☐Yes ☐No Anxiety
☐Yes ☐No Anemia	☐Yes ☐No Seizures	☐Yes ☐No Depression
☐Yes ☐No Diabetes type 1 or 2	☐Yes ☐No Alzheimer's disease or dementia	☐Yes ☐No ADD/ADHD
☐Yes ☐No Hypoglycemia	☐Yes ☐No Memory loss	☐Yes ☐No Eating disorder
☐Yes ☐No Osteoporosis/osteopenia	☐Yes ☐No Seasonal allergies/hay fever	☐Yes ☐No Psychiatric care
☐Yes ☐No Eye disease	☐Yes ☐No Sexually transmitted disease	☐Yes ☐No Drug addiction

IV. Are you allergic to or have you had a reaction to any of the following? *(Please circle Yes or No for each)*

☐Yes ☐No Aspirin	☐Yes ☐No Valium	☐Yes ☐No Acrylics
☐Yes ☐No Penicillin	☐Yes ☐No Local anesthetics	☐Yes ☐No Metals
☐Yes ☐No Codeine	☐Yes ☐No Food if Yes, what?	☐Yes ☐No Latex
☐Yes ☐No Vicodin	☐Yes ☐No Gluten	☐ Other:_____

V. Are you taking or have you taken any of the following in the last three months? *(Please circle Yes or No for each)*

☐Yes ☐No Recreational drugs	☐Yes ☐No Bisphosphonates (i.e. Fosamax)	☐Yes ☐No Antibiotics
☐Yes ☐No Over-the-counter medications	☐Yes ☐No Tobacco in any form frequency:	☐Yes ☐No Alcohol
☐Yes ☐No Cortico-steroids	☐Yes ☐No Supplements/vitamins	☐Yes ☐No Blood Thinners

Please list all current medications:_____

VI. Women only *(Please circle Yes or No for each)*

☐Yes ☐No Are you or are you trying to become pregnant? ☐Yes ☐No Are you taking birth control pills? ☐Yes ☐No Are you nursing?

VII. All patients *(Please circle Yes or No for each)*

☐Yes ☐No Do you have or have you had any other diseases or medical problems NOT listed on this form? if Yes, what?_____
☐Yes ☐No Do you need premedication prior to visits? if Yes, what perscription? _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my provider of any change in my health and/or medication. Further, 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 the completion of this form._____
Signature of Patient(Parent/Guardian) Date

For office use only: _____
Signature of Dentist Date

Updates: Date_____ Changes/Initials_____

Date_____ Changes/Initials_____ Date_____ Changes/Initials_____
Date_____ Changes/Initials_____ Date_____ Changes/Initials_____
Date_____ Changes/Initials_____ Date_____ Changes/Initials_____

Dental Health History Form

What are your goals in coming to our practice today?_____

How long has it been since you've been to the dentist?_____ **What was done then?**_____

How often do you typically visit the dentist?_____ **Date of last radiographs (X-rays)?**_____

Former Dentist's name_____**City**_____**State**_____

Why did you leave your previous dentist?_____

◯Yes ◯No **Are you currently experiencing pain in or around your mouth?** if Yes, explain

_____

◯Yes ◯No **Have you been anxious about having dental treatment?** if Yes, explain

_____

◯Yes ◯No **Do you brush your teeth?** if Yes, how often _____

◯Yes ◯No **Do you floss your teeth?** if Yes, how often _____

◯Yes ◯No **Do you use any mouthwashes?** if Yes, what kind and how often_____

◯Yes ◯No **Do your gums ever bleed?** if Yes, when and how often _____

◯Yes ◯No **Have you ever had orthodontic (braces) treatment?** if Yes, at what age_____

◯Yes ◯No **Have you ever had periodontal (gum tissue) treatment, such as deep cleanings, root planing, or periodontal surgery?** if Yes, when _____

◯Yes ◯No **Does food catch between your teeth?** if Yes, where in your mouth _____

◯Yes ◯No **Do you have any loose teeth?** if Yes, where in your mouth _____

◯Yes ◯No **Do you ever have clicking, popping or discomfort in the jaw joint?**

◯Yes ◯No **Do you brux or grind your teeth?**

◯Yes ◯No **Do you wear a night guard (splint)?** if Yes, how often _____ since when _____

◯Yes ◯No **Do you wear complete or partial dentures?** if Yes, year of placement _____ are they comfortable

_____

What concerns do you currently have with your oral health and smile? *(check all that apply)*

- ☐ Jaw joint (TMJ) pain
- ☐ Clenching or grinding of teeth
- ☐ Discolored teeth
- ☐ Crowding/Crooked teeth
- ☐ Missing teeth
- ☐ Spaces in between teeth
- ☐ Loose tooth/teeth
- ☐ Tooth shape/size
- ☐ Overbite
- ☐ Underbite
- ☐ Uncomfortable bite
- ☐ Old restorations
- ☐ Speech problems
- ☐ Dry mouth sensation
- ☐ Cold sores
- ☐ Frequent canker sores
- ☐ Ill-fitting denture/partial
- ☐ Sensitivity to hot/cold/sweet
- ☐ Food trapping between teeth
- ☐ Bleeding gums while brushing/flossing
- ☐ Chewing difficulty
- ☐ Bad breath
- ☐ Other_____

If you could change anything about your smile what would you change?_____

Are you interested in learning more about the following? *(check all that apply)*

- ☐ Teeth whitening
- ☐ Orthodontic treatment
- ☐ Dental implants
- ☐ How to prevent periodontal disease
- ☐ At-home oral hygiene care
- ☐ Oral hygiene care for infants and toddlers
- ☐ Other_____