



PERSONAL INFORMATION

Patients Name _____ Birth date _____

How did you hear of our office? _____

How do you wish to be addressed? _____

Status (please circle): single married separated divorced widowed minor other

Address _____ City _____ State _____ Zip _____

Email _____ Social Security # _____ Drivers license # _____

Home Phone Number _____ Mobile Number _____ Alternate Number _____

Occupation _____ Employer Address _____

Employer _____ Phone Number _____

Spouse Name _____ Spouse Employed by _____

Emergency Contact _____ Relationship _____ Phone Number _____

INSURANCE INFORMATION

Primary Insurance

Person Financially Responsible _____ Relationship _____

Birth date _____ Social Security Number _____ Policy/Group # _____

Name of Insurance Company _____

Address of Insurance _____

Phone Number for the Insurance _____

Secondary Insurance

Person Financially Responsible _____ Relationship _____

Birth date _____ Social Security Number _____ Policy/Group # _____

Name of Insurance Company _____

Address of Insurance _____

Phone Number for the Insurance _____

Please Answer All Questions as accurately as possible – all information is kept confidential

DENTAL HISTORY

Previous Dentist's name _____

Address _____ Phone # _____

Purpose of initial visit _____

How long since your last visit _____

What was done at that time? _____

Were x-rays last taken? _____ Date _____ Last cleaning _____

Have any areas of concern? _____

How often do you brush? _____ Floss _____ Have you lost any teeth or have any removed? _____

If so, Why/Where? _____

Do you have replacements for the missing teeth? _____

Bridge _____ how old _____

Implant _____ how old _____

Denture _____ how old _____

Are you happy with the replacement? _____ Would you like to know about permanent replacements? _____

Does food get caught between your teeth? _____ Are your teeth sensitive to: Hot ___ Cold ___ Sweets ___ Pressure ___

Do you feel your breath is offensive? ___ Do your gums bleed or hurt? _____ When? _____

Ever had gum treatment or surgery? _____ Where? _____ When? _____

Have you had Orthodontic work done? _____ How long ago? _____

In your opinion, tell us what you think the present state of the health of your mouth is?

Do you have any family or friends that already come to our office? _____

What do you know about our office and what expectations do you have?

How healthy would you like your mouth to be? (Circle one): "Don't really care" "Average" "The best it can be"

Should you need treatment, at what point would you like us to address it? (Circle one):

"When my tooth hurts or breaks" "When the symptoms are becoming worse" "At the first sign of a problem"

What quality of dentistry do you want us to recommend? (Circle one): "Just Patch it" "Average" "Ideal / The Best"

We have the ability to look at your mouth from 3 different perspectives. How would you like us to view your mouth?

(Circle all that apply): "As a GENERAL dentist" "As a COSMETIC dentist" "As a FUNCTIONAL dentist"

How do you feel about the overall appearance of your smile?

Trust if very important to us, what are your expectations in order to entrust us with your overall oral health?

Tell us about a good dental experience you have had in the past

Tell us about a bad experience at the dental office

Has fear ever been an issue for you in a dental office? _____

What caused you to leave your last dental office? _____

Has time ever been a factor in getting your dental work done? _____

Has the cost of dental treatment been a concern for you? If yes, what can we do to assist you?

Is there any additional information that you would like to let us know or consider?

HEALTH HISTORY

Physician's Name _____ Phone Number _____

When was your last complete physical exam? _____ Have you been under the care of a medical doctor in the past two years? Yes/No

If Yes, please specify _____

Are you taking any medication now, including prescription or over the counter drugs ie. aspirin? Yes / No

If so please list _____

Are you aware of having an allergic reaction to any medication or substance? Yes/ No

(Penicillin/Amoxicillin/Codeine ETC) Please list all:

PLEASE CIRCLE ALL THAT APPLY

Heart Concerns	Yes	No	Headaches	Yes	No
Congenital Heart Disease	Yes	No	Jaw Pain	Yes	No
Heart Murmur	Yes	No	Jaw Popping	Yes	No
Mitral Valve Prolapse	Yes	No	Congested Ears	Yes	No
Artificial Heart Valve	Yes	No	Limited Opening	Yes	No
Pacemaker	Yes	No	Ringling Ears	Yes	No
High Blood Pressure	Yes	No	Dizziness	Yes	No
Stroke	Yes	No	Grinding	Yes	No
Liver disease/ Jaundice	Yes	No	Clenching	Yes	No
Artificial Joints	Yes	No	Loose Teeth	Yes	No
Kidney Trouble	Yes	No	Difficulty Chewing	Yes	No
Diabetes	Yes	No	Difficulty Swallowing	Yes	No
Hepatitis	Yes	No	Facial Pain	Yes	No
Neurological Disorders	Yes	No	Sensitive Teeth	Yes	No
Radiation/ Chemotherapy	Yes	No	Neck Ache	Yes	No
Epilepsy/ Seizures	Yes	No	Bell's Palsy	Yes	No
AIDS/HIV	Yes	No	Trigeminal Neuralgia	Yes	No
Psychiatric/ Psychological	Yes	No	Tingling in Arms/ Fingers	Yes	No
Latex Sensitivity	Yes	No	Insomnia/ Frequent Waking	Yes	No

Do you have any other allergies or hives? YES / NO Do you have or have had asthma? YES / NO
Are you pregnant or suspect you may be? YES / NO Do you or have you had T.B.? YES / NO
Do you use any birth control medications? YES / NO Do you consume alcoholic beverages? YES / NO
Do routinely take health related substance? YES / NO Do you habitually use controlled substances? YES / NO

(vitamins, herbal supplements, natural products) Which ones? _____

Have you ever had rheumatic fever? YES / NO

Have you ever had a serious illness or major surgery. YES / NO

Please List _____

Do you have inflammatory disease, such as arthritis or Rheumatism? YES / NO

Do you have any blood disorders, such as anemia, leukemia, etc.? YES / NO

Have you ever bled excessively after being cut or injured? YES / NO

Do you have any stomach problems? YES / NO

Do you or have you had venereal disease? YES / NO

Do you smoke, chew, use snuff, or any other forms of tobacco? YES / NO

Have you taken any prescription drugs fenfluramine, fenfluramine combined with phentermine (fen- phen), exfenfluramine (redux), or other weight loss products? YES / NO

Have you seen an ENT (ear, nose, and throat doctor)? YES/NO

Have you seen a Chiropractor? YES/NO Have you seen a Neurologist? YES/NO

Have you had braces? YES/NO

Do you have any disease condition, or problem not listed? If so, explain:

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to Dr. Kathrina Agatep and Dental Design Spa all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr. Kathrina Agatep and Dental Design SD may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

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