

# Robert J. Harris, D.M.D.

# Welcome!

FELLOW ACADEMY OF GENERAL DENTISTRY

Thank you for your visit today! We appreciate you trusting us to care for your dental health, and are pleased to welcome you to our practice. To help us serve you better, please take a few moments to fill out the following form as completely as you can. If you have any questions, just ask – we will be glad to help. We look forward to working with you!

## Patient Information

Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Social Security # \_\_\_\_\_ Drivers Lic # \_\_\_\_\_

Address \_\_\_\_\_ Cell Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ E-Mail \_\_\_\_\_

Gender  Male  Female Age \_\_\_\_\_ Birthdate \_\_\_\_\_  Single  Married  Widowed  Other

Occupation \_\_\_\_\_ Employed by \_\_\_\_\_

Business Address \_\_\_\_\_ Work Phone \_\_\_\_\_

Whom may we notify in case of an emergency? \_\_\_\_\_ Phone \_\_\_\_\_

Whom may we thank for referring you to our practice? \_\_\_ Friend \_\_\_ Relative \_\_\_ Dental Office \_\_\_ Web Site \_\_\_ Insurance  
\_\_\_ News Paper/Magazine \_\_\_ Work \_\_\_ Yellow Pages \_\_\_ Other

Name of referral? \_\_\_\_\_

Are you a FT Student? \_\_\_ Yes \_\_\_ No Name of School/ University? \_\_\_\_\_

## Primary Insurance

Who is responsible for this account?

Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Relation to patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_

Address (if different from patient's) \_\_\_\_\_ E-Mail \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Work Phone \_\_\_\_\_

Insurance Company \_\_\_\_\_

Contract or Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

## Secondary Insurance

Is patient covered by additional insurance?  Yes  No

Subscriber name \_\_\_\_\_ Relation to patient \_\_\_\_\_

Address (if different from patient's) \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Subscriber employed by \_\_\_\_\_ Work Phone \_\_\_\_\_

Insurance Company \_\_\_\_\_ Social Security # \_\_\_\_\_

Contract or Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

Reason for today's visit \_\_\_\_\_ Are you in discomfort? \_\_\_\_\_  
Previous Dentist \_\_\_\_\_ Address \_\_\_\_\_  
Date of Last Dental Care \_\_\_\_\_ Do you take antibiotics before dental appointments? \_\_\_\_\_

Please check ( ✓ ) if you have had trouble with any of the following:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Bad Breath                   | <input type="checkbox"/> Periodontal Treatment | <input type="checkbox"/> Sensitivity when biting   |
| <input type="checkbox"/> Bleeding Gums                | <input type="checkbox"/> Sensitivity to Cold   | <input type="checkbox"/> Sores or Growths in Mouth |
| <input type="checkbox"/> Clicking or Popping Jaw      | <input type="checkbox"/> Sensitivity to Heat   | <input type="checkbox"/> Frequent cold sores       |
| <input type="checkbox"/> Grinding Teeth               | <input type="checkbox"/> Sensitivity to Sweets | <input type="checkbox"/> Food Caught between Teeth |
| <input type="checkbox"/> Loose Teeth/ Broken Fillings |  |  |

How often do you floss? \_\_\_\_\_ How often do you brush? \_\_\_\_\_

### *Medical History*

Physician's Name \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

Previous hospitalizations, illnesses, or operations (please describe, and give approximate date) \_\_\_\_\_

Have you ever had a blood transfusion:  yes  no If yes, please give approximate date \_\_\_\_\_

**Women:** Are you pregnant or trying to become pregnant?  yes  no Nursing?  yes  no Taking birth control?  yes  no

Please check ( ✓ ) if you have or have had any of the following:

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> AIDS                    | <input type="checkbox"/> Cough, Persistent   | <input type="checkbox"/> HIV Positive          | <input type="checkbox"/> Skin Rash               |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Cough up Blood      | <input type="checkbox"/> Jaw Pain              | <input type="checkbox"/> Stroke                  |
| <input type="checkbox"/> Arthritis, Rheumatism   | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Swelling of Feet/Ankles |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Thyroid Problems        |
| <input type="checkbox"/> Artificial Joints       | <input type="checkbox"/> Fainting            | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tobacco Habit           |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Nervous Problems      | <input type="checkbox"/> Tonsillitis             |
| <input type="checkbox"/> Back Problems           | <input type="checkbox"/> Headaches           | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Tuberculosis            |
| <input type="checkbox"/> Blood Disease           | <input type="checkbox"/> Heart Murmur        | <input type="checkbox"/> Psychiatric Care      | <input type="checkbox"/> Ulcer                   |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Heart Problems      | <input type="checkbox"/> Radiation Treatment   | <input type="checkbox"/> Venereal Disease        |
| <input type="checkbox"/> Chemical Dependency     | Describe _____                               | <input type="checkbox"/> Respiratory Disease   |  |
| <input type="checkbox"/> Chemotherapy            | <input type="checkbox"/> Hemophilia          | <input type="checkbox"/> Rheumatic Fever       |  |
| <input type="checkbox"/> Circulatory Problems    | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Scarlet Fever         |  |
| <input type="checkbox"/> Cortisone Treatments    | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shortness of Breath   |  |

Please list any medications you are currently taking \_\_\_\_\_

Please list any allergies, or allergic reactions to medications you have taken: \_\_\_\_\_

Do you have any other health conditions that need further clarification? \_\_\_\_\_ Do you take blood thinners? \_\_\_\_\_

### CONSENT

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. The undersigned hereby authorizes Dr. Harris to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Harris to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. Harris to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain amount of risk. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners.

I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and Dr. Harris and that **I am still fully responsible for all dental fees**. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to Dr. Harris. Any payments received by Dr. Harris from my insurance carrier will be credited to my account, or refunded to me if I have paid the dental fees incurred at the time of service. I further understand that a late charge will be added to any overdue balance (1.5% per month or 18% annually). In the event my account is referred to a collection agency or attorney, I will be responsible for all collection fees and/or legal fees due to the delinquency of my account.

Patient Name: \_\_\_\_\_ Patient Signature: \_\_\_\_\_  
(or parent/guardian)

Date: \_\_\_\_\_ Dentist Signature: \_\_\_\_\_ Comments \_\_\_\_\_

## PATIENT QUESTIONNAIRE

We pride ourselves on meeting our patient's necessities and concerns; please, fill this important questionnaire so we may better understand your needs. THANKS!

1. Summarize your past experiences with dentists; is there anything we should try to repeat or avoid?
2. What has been your best dental experience and why was it good for you?
3. Please describe what you think a good dentist is like:
4. If you could change your smile, what would you change?
5. How would you like your teeth to be 15 years from now?
6. On a scale of 1-10 (10 being the best) how do you feel about the condition of your mouth?
7. On the same scale how would you like it to be?

8. What is the most important thing to you about your teeth?

9. What is your primary dental concern?

10. What is your family's dental history?\_(Parents, Grandparents)

11. Will Insurance have a role in achieving your objectives?

12. Have you thought about a budget for your dental treatment?

13. What kind of work do you do, and where do you work?

14. Does your smile affect a positive effect in your work?