heringerdentistry

Dr. Everett E. Heringer, DDS
1839 East Capitol Avenue
Bismarck, ND 58501
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Patient Information Name:

_____ Preferred Name: _____ Male ◯ Female ◯

Last First Mi

Birthdate: ____/____/____ Social Security #: _____ Preferred Pharmacy: _____

Single ◯ Married ◯ Divorced ◯ Widowed ◯ Separated ◯

E-mail Address: _____ I would like to be contacted by e-mail ◯ By Text ◯

Home Address: _____

Street City State Zip

Mailing Address: _____

Street City State Zip

Home Phone: (___) ___-____ Cell #: (___) ___-____ Work #: (___) ___-____ Ext. _____

What is the best phone number to contact you? (___) ___-____ Driver's License #: _____

Whom may we thank for referring you? _____

Did you hear of us from? Web Site ◯ Yellow Pages ◯ TV Commercial ◯ Other ◯

Other family members seen by us: _____

Employer: _____ Occupation: _____

Employer's Address: _____

Street City State Zip

Responsible Party (if someone other than the patient)

Name: _____ Birthdate: ____/____/____ Social Security #: _____

Last First

Mailing Address: _____

Street City State Zip

Home Phone: (___) ___-____ Cell #: (___) ___-____ Work #: (___) ___-____ Ext. _____

Emergency Contact Information

Name: _____ Relationship: _____

Home Phone: (___) ___-____ Cell #: (___) ___-____ Work #: (___) ___-____ Ext. _____

Primary Dental Insurance ~ Please provide your dental insurance card at appointment

Insurance Co. Name: _____ Phone #: (___) ___-____ Group #: _____

Insured's Name: _____ Insured's Member ID #: _____

Insured's Address: _____

Street City State Zip

Insured's B-day: ___/___/___ Relationship: _____ Insured's Employer: _____

Secondary Dental Insurance

Insurance Co. Name: _____ Phone #: (___) ___-____ Group #: _____

Insured's Name: _____ Insured's Member ID #: _____

Insured's Address: _____

Street City State Zip

Insured's B-day: ___/___/___ Relationship: _____ Insured's Employer: _____

Dental History

Why have you come to the dentist today?

Are you currently in pain? Yes ◯ No ◯

Do you require antibiotics prior to dental treatment?
Yes ◯ No ◯

Your current dental health is:
Good ◯ Fair ◯ Poor ◯

Do you floss daily? Yes ◯ No ◯

Do you brush daily? Yes ◯ No ◯

Type of toothbrush?
Manual Full ◯ Electric ◯ End Tuft ◯

Do your gums bleed? Yes ◯ No ◯

Have you ever had periodontal (gum) disease?
Yes ◯ No ◯

Are your teeth sensitive to heat, cold, or anything else?
Yes they are to all of the above

Do you have any loose teeth?

Yes ◯ No ◯

Prev./Present Dentist:_____
Last visit date: _____

Are you satisfied with your smile?
Yes ◯ No ◯

If no, please explain what you would like to change:

Have you ever had any serious complications with prior dental treatment? Yes ◯ No ◯

If yes, please explain:

Have you had any head, neck, or jaw injuries?
Yes ◯ No ◯

Do you have frequent headaches? Yes ◯ No ◯

Clicking? Yes ◯ No ◯
Pain (joint, ear, side of face)? Yes ◯ No ◯
Difficulty opening or closing? Yes ◯ No ◯

Difficulty chewing? Yes ◯ No ◯

Have you ever had orthodontic treatment? Yes ◯ No ◯

Have you ever whitened your teeth? Yes ◯ No ◯

If yes, what type of product? _____

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need. I understand that I am responsible for payment of services rendered. As a courtesy, Dr. Everett Heringer will file my dental insurance claims to be paid to the dental office. I have received a copy of this office's Notice of Privacy Practices.

Signature:_____ Date: _____