

**Why do we ask these questions?**

Answer: Because we are focused on wellness and helping you avoid unnecessary disease and higher health costs!

**Explanation:** Our office believes in the current science – that the mouth and general health are connected, also that many health problems are preventable and avoidable. That is why we believe that proper identification of health risk factors and condition can help us design and approach to your care that will improve your health through advanced preventive care, appropriate treatment strategies, and wellness coaching. We recognize that some questions about weight, race, gender and diet (among other particulars generally associated with medical visits) may at first seem unrelated to your dental visit. However, specific health issues such as cancer, heart disease airway size/quality, and the risk for many disease conditions are connected to the mouth and can affect oral health and vice-versa.

**Patients Name:** \_\_\_\_\_ **D.O.B.** \_\_\_\_\_ **Gender:**  M / F

**PATIENT INFORMATION, Part 1**

**TODAY'S DATE** \_\_\_\_\_

<b>Home Address</b>		<b>City</b>	<b>State</b>	<b>Zip</b>
<b>Home Phone #</b>	<i>Please Circle One:</i> Single   Married   Separated   Widow			<b>Patient's Social Security Number</b>
<b>Employer</b>	<b>Occupation</b>		<b>Work Phone #</b>	
<i>If patient is a minor, we need Mother's &amp; Father's Names &amp; birth dates</i>				
<b>Person responsible for account (Please also see Part 3.):</b>			<b>Patient's/Guardian's Driver's License Number:</b>	
<b>Name of spouse ( or parent if minor)</b>			<b>Patient's/Guardian's E-mail:</b>	<b>Patient's/Guardian's cell:</b>
<b>Spouse's (or parent's) employer</b>		<b>Spouse's Soc. Sec. #</b>	<b>Work phone #</b>	
<b>EMERGENCY INFORMATION</b>				
<i>Name, Address, &amp; Telephone of a relative not living with you:</i>				
<b>How did you hear about our office?</b>				
<b>Reason for this visit?</b>				

<b>DENTAL INSURANCE INFORMATION (Primary Carrier)</b>			<b>Dual insurance coverage, complete this for the second coverage</b>		
<b>Insured's name</b>	<b>DOB</b>	<b>SS#</b>	<b>Insured's name</b>	<b>DOB</b>	<b>SS#</b>
<b>Insured's employer</b>			<b>Insured's employer</b>		
<b>Insurance Co</b>			<b>Insurance Co</b>		
<b>Insurance Co Address</b>			<b>Insurance Co Address</b>		
<b>Phone #</b>			<b>Phone #</b>		
<b>Group #</b>	<b>Policy #</b>		<b>Group #</b>		<b>Local #</b>
<b>Patient's/Parent's/Guardian's Signature</b>			<b>Today's Date</b>		

## ACKNOWLEDGEMENT AND AUTHORITY, Part 2

The information on this page and the dental/medical histories are correct to the best of my knowledge. I hereby authorize Ryan Tracy, D.M.D. to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I hereby authorize payment of my group insurance benefits directly to Ryan Tracy, D.M.D., P.L.L.C. I understand that Ryan Tracy, D.M.D., P.L.L.C. may release my dental, medical and other information about my dental treatment to third party payors and/or other health professionals in accordance with HIPPA regulations. I acknowledge full responsibility for the payment of all fees for services rendered. If desired, Ryan Tracy, D.M.D., P.L.L.C. may file a claim on my behalf with my insurance company. I understand that I am responsible for any charges and fees for which my insurance company denies payment. In addition, I agree to pay my deductible and any estimated patient portion of fees at the time of service.

I have received a copy of the HIPAA Privacy Policy as required by law.

I prefer to be contacted via:

- home phone
- work phone
- email and US Mail (check all that apply).

X \_\_\_\_\_  
Adult Patient; Parent; Step-Parent or Guardian

\_\_\_\_\_  
Date

## PERSON RESPONSIBLE FOR ACCOUNT, Part 3

Please check one:

- Patient
- Husband (or Father)
- Other \_\_\_\_\_
- Guardian
- Wife (or Mother)

If not the patient, please print your name: \_\_\_\_\_

Responsible party has an account with this office:

METHOD OF PAYMENT (unless otherwise arranged)

I will pay in full at each appointment via:  Cash  Check  Visa MC  AmEx  Disc  
Card # \_\_\_\_\_ Exp \_\_\_\_\_

- I declare and understand that I am responsible for all charges incurred for services rendered for the patient identified in Part 1 of this document, including any charges that are ultimately denied by my/their insurance company. I will pay the deductible and any estimated patient portion of fees at the time of service.

X \_\_\_\_\_  
Person Responsible For Account

\_\_\_\_\_  
Date

## DENTAL HISTORY, Part 4

Please check Yes or No to each of the following questions.

YES      NO

If you could whiten your teeth for a cost anyone could afford, would you do it?           

-Sensitivity (hot, cold, sweet)  
Where? UR LR UL LL           

Do you smoke or use chewing tobacco?  
How much?      For how long?           

-Headaches, ear aches, neck or jaw joint pain           

**If I could change my smile, I would:**

-Mouth ulcers or cold sores (lasting 2+weeks)           

-Make my teeth whiter           

-Teeth or fillings breaking           

-Make my teeth straighter           

-Grinding or clenching teeth           

-Close spaces           

-Bleeding, swollen or irritated gums           

-Replace metal fillings with tooth-colored restorations           

-Loose, tipped or shifting teeth           

-Repair chipped teeth           

-Bad breath           

-Replace missing teeth           

-Dentures with persistent sores           

-Replace old crowns that don't match           

**Do you have or have you had any of the following?**

-Have a smile makeover           

-Dentures           

-Partial dentures           

**On a scale of 1 – 10, with 10 being highest:**

-Braces           

-Gum treatments           

-How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

**Please share the following dates:**

-Your last cleaning      \_\_\_ / \_\_\_

-Where would you rate your current dental health?

-Your last oral cancer screening      \_\_\_ / \_\_\_

1 2 3 4 5 6 7 8 9 10

-Your last complete X-Rays      \_\_\_ / \_\_\_

**Name of previous dentist:**

**Why did you leave your previous dentist?**

\_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

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

**What is the most important thing to you about your dental health and the future of your smile?**

**What is the most important thing to you about your dental visit today?**

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## HEALTH HISTORY, Part 5

Please check Yes or No to each of the following questions.

<b>Diseases &amp; Conditions</b>		
<b>Yes No</b>	<b>Yes No</b>	<b>Yes No</b>
<input type="checkbox"/> <input type="checkbox"/> Acid Reflux(GERD)	<input type="checkbox"/> <input type="checkbox"/> HPV	<input type="checkbox"/> <input type="checkbox"/> Nervous disorder
<input type="checkbox"/> <input type="checkbox"/> AIDS /HIV positive	<input type="checkbox"/> <input type="checkbox"/> Hay fever or sinus problems	<input type="checkbox"/> <input type="checkbox"/> Osteoporosis (bone loss)
<input type="checkbox"/> <input type="checkbox"/> Arthritis	<input type="checkbox"/> <input type="checkbox"/> Head injuries	<input type="checkbox"/> <input type="checkbox"/> Pacemaker
<input type="checkbox"/> <input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> <input type="checkbox"/> Heart conditions	<input type="checkbox"/> <input type="checkbox"/> Radiation therapy
<input type="checkbox"/> <input type="checkbox"/> Artificial Joints	<input type="checkbox"/> <input type="checkbox"/> Heart disease	<input type="checkbox"/> <input type="checkbox"/> Respiratory problems
<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> Heart lesions(congenital)	<input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> <input type="checkbox"/> Bleeding/ clotting problems	<input type="checkbox"/> <input type="checkbox"/> Heart murmur/damaged heart valve	<input type="checkbox"/> <input type="checkbox"/> Seizures
<input type="checkbox"/> <input type="checkbox"/> Cancer(type)_____	<input type="checkbox"/> <input type="checkbox"/> Heart surgery	<input type="checkbox"/> <input type="checkbox"/> Sjogren's syndrome
<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> Hepatitis(type)_____	<input type="checkbox"/> <input type="checkbox"/> Stomach problems
<input type="checkbox"/> <input type="checkbox"/> Dizziness	<input type="checkbox"/> <input type="checkbox"/> High Blood pressure	<input type="checkbox"/> <input type="checkbox"/> Stroke
<input type="checkbox"/> <input type="checkbox"/> Drug Addiction	<input type="checkbox"/> <input type="checkbox"/> Jaundice	<input type="checkbox"/> <input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> <input type="checkbox"/> Emphysema or COPD	<input type="checkbox"/> <input type="checkbox"/> Kidney disease	<input type="checkbox"/> <input type="checkbox"/> Tuberculosis
<input type="checkbox"/> <input type="checkbox"/> Epilepsy	<input type="checkbox"/> <input type="checkbox"/> Liver disease or Hepatitis	<input type="checkbox"/> <input type="checkbox"/> Ulcers
<input type="checkbox"/> <input type="checkbox"/> Fainting	<input type="checkbox"/> <input type="checkbox"/> Mental Disorder	<input type="checkbox"/> <input type="checkbox"/> Venereal Disease
<input type="checkbox"/> <input type="checkbox"/> Glaucoma	<input type="checkbox"/> <input type="checkbox"/> Nausea/ Vomiting	<input type="checkbox"/> <input type="checkbox"/> Other
<input type="checkbox"/> <input type="checkbox"/> Growths		
<b>Sleep</b>		
<b>Yes No</b>		<b>General Health - Women</b>
<input type="checkbox"/> <input type="checkbox"/> Snoring		<input type="checkbox"/> <input type="checkbox"/> Birth control pills
<input type="checkbox"/> <input type="checkbox"/> Poor sleep		<input type="checkbox"/> <input type="checkbox"/> Pregnant
<input type="checkbox"/> <input type="checkbox"/> Stop breathing during sleep		<input type="checkbox"/> 1-3 mo <input type="checkbox"/> 3-6mo <input type="checkbox"/> 6-9 mo
<input type="checkbox"/> <input type="checkbox"/> Obstructive Sleep Apnea		<input type="checkbox"/> <input type="checkbox"/> Nursing mother
<input type="checkbox"/> <input type="checkbox"/> CPAP		<input type="checkbox"/> <input type="checkbox"/> Other
<input type="checkbox"/> <input type="checkbox"/> Oral sleep appliance		
<input type="checkbox"/> <input type="checkbox"/> Other		
<b>Have you taken any of the following:</b>		
<b>Yes No</b>	<b>Yes No</b>	<b>Yes No</b>
<input type="checkbox"/> <input type="checkbox"/> Breathing medications	<input type="checkbox"/> <input type="checkbox"/> Antidepressants	<input type="checkbox"/> <input type="checkbox"/> Sleeping pills
<input type="checkbox"/> <input type="checkbox"/> Aspirin or blood thinners	<input type="checkbox"/> <input type="checkbox"/> Dilantin or seizure medication	<input type="checkbox"/> <input type="checkbox"/> Immunosuppressant's
<input type="checkbox"/> <input type="checkbox"/> Calcium channel blockers	<input type="checkbox"/> <input type="checkbox"/> Bisphosphonates (Fosamax)	<input type="checkbox"/> <input type="checkbox"/> Other
<b>Additional Notes:</b>		

## PATIENT MEDICATIONS, SUPPLEMENTS & SURGERIES, Part 6

List the medications that you are currently taking:

Please check Yes or No to each of the following questions.

Do you have any allergies or reaction to:

Yes	No	Yes	No	Surgeries:
<input type="checkbox"/>	<input type="checkbox"/> Aspirin	<input type="checkbox"/>	<input type="checkbox"/> Penicillin	<b>Yes No</b>
<input type="checkbox"/>	<input type="checkbox"/> Erythromycin	<input type="checkbox"/>	<input type="checkbox"/> Codeine	<input type="checkbox"/> <input type="checkbox"/> Joint or bone surgery
<input type="checkbox"/>	<input type="checkbox"/> Latex	<input type="checkbox"/>	<input type="checkbox"/> Metals	<input type="checkbox"/> <input type="checkbox"/> Other
<input type="checkbox"/>	<input type="checkbox"/> Local Anesthetic	<input type="checkbox"/>	<input type="checkbox"/> Other	
<input type="checkbox"/>	<input type="checkbox"/> Nitrous Oxide			
<input type="checkbox"/>	<input type="checkbox"/> Other			

Are you under a physician's care? Yes  No

Reason?

## NUTRITION & LIFESTYLE, Part 7

What is your diet rating?	Yes No	Yes No
<input type="checkbox"/> Good	<input type="checkbox"/> <input type="checkbox"/> Eating disorders	<input type="checkbox"/> <input type="checkbox"/> Do NOT exercise regularly
<input type="checkbox"/> Fair	<input type="checkbox"/> <input type="checkbox"/> Taking dietary supplements	<input type="checkbox"/> <input type="checkbox"/> Lemon sucking
<input type="checkbox"/> Poor	<input type="checkbox"/> <input type="checkbox"/> Drinking carbonated /sweetened beverages	<input type="checkbox"/> <input type="checkbox"/> Use gum, cough drops or breath mints regularly
Height _____ /Weight _____	<input type="checkbox"/> <input type="checkbox"/> Frequent snacking or eating	<input type="checkbox"/> <input type="checkbox"/> High refined carbohydrate consumption
<input type="checkbox"/> Open to receiving information or help regarding nutrition		

## TOBACCO, ALCOHOL & DRUGS, Part 8

Please check Yes or No to each of the following questions.

Yes No	Yes No	Yes No
<input type="checkbox"/> <input type="checkbox"/> Women: Two or more drinks per day average	<input type="checkbox"/> <input type="checkbox"/> Current use of smokeless tobacco- Type: _____	<input type="checkbox"/> <input type="checkbox"/> Recreational drugs
<input type="checkbox"/> <input type="checkbox"/> Men: Three or more drinks per day average	Amount per day? _____	<input type="checkbox"/> <input type="checkbox"/> Chronic exposure to 2 <sup>nd</sup> hand smoke?
<input type="checkbox"/> <input type="checkbox"/> Current smoker: Packs a day? _____	<input type="checkbox"/> <input type="checkbox"/> Former user: When did you quit? _____	<input type="checkbox"/> <input type="checkbox"/> Interested in quitting
<input type="checkbox"/> <input type="checkbox"/> Former smoker: When did you quit? _____		

**Additional Notes:**