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.

Patient's Name: _____ D.O.B._____ Gender: M / F___

PATIENT INFORMATION, Part 1

TODAY'S DATE_____

Home Address	**City**	**State**	**Zip code**
Home Phone # / **Cell Phone #**	***Please Circle One:*** Single Married Separated Widow		**Patient's Social Security Number**
Employer	**Occupation**		**Work Phone #**

Mailing address at work – *Please give us instructions on how to get something* ***to you at your place of work****.*

Work Address **Attn:**	**Work City**	**Work State**	**Work Zip code**

If patient is a minor, we need Mother's & Father's Names & birth dates

Person responsible for account (Please also see Part 3.):	**Patient's/Guardian's Driver's License Number:**	
Name of spouse (or parent if minor)	**Patient's/Guardian's E-mail:**	**Patient's/Guardian's cell:**
Spouse's (or parent's) employer	**Spouse's Soc. Sec. #**	**Work phone #**

EMERGENCY INFORMATION

Name, Address, & Telephone of a relative not living with you:

How did you hear about our office?

Reason for this visit?

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

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
-Sensitivity (hot, cold, sweet) *Where? UR LR UL LL*	☐	☐
-Headaches, ear aches, neck or jaw joint pain	☐	☐
-Mouth ulcers or cold sores (lasting 2+weeks)	☐	☐
-Teeth or fillings breaking	☐	☐
-Grinding or clenching teeth	☐	☐
-Bleeding, swollen or irritated gums	☐	☐
-Loose, tipped or shifting teeth	☐	☐
-Bad breath	☐	☐
-Dentures with persistent sores	☐	☐

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

-Dentures	☐	☐
-Partial dentures	☐	☐
-Braces	☐	☐
-Gum treatments	☐	☐

Please share the following dates:

-Your last cleaning ___ / ___

-Your last oral cancer screening ___ / ___

-Your last complete X-Rays ___ / ___

Name of previous dentist:

_____

City _____ **State** _____

Phone Number _____

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

_____

_____

	YES	NO
If you could whiten your teeth for a cost anyone could afford, would you do it?	☐	☐
Do you smoke or use chewing tobacco? *How much? For how long?*	☐	☐
If I could change my smile, I would:		
-Make my teeth whiter	☐	☐
-Make my teeth straighter	☐	☐
-Close spaces	☐	☐
-Replace metal fillings with tooth-colored restorations	☐	☐
-Repair chipped teeth	☐	☐
-Replace missing teeth	☐	☐
-Replace old crowns that don't match	☐	☐
-Have a smile makeover	☐	☐

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

-How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

-Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist?

_____

_____

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.

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

Additional Notes:

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		Yes	No	
☐	☐	*Aspirin*	☐	☐	*Penicillin*	**Surgeries:**		
☐	☐	*Erythromycin*	☐	☐	*Codeine*	**Yes**	**No**	
☐	☐	*Latex*	☐	☐	*Metals*	☐	☐	*Joint or bone surgery*
☐	☐	*Local Anesthetic*	☐	☐	*Other*	☐	☐	*Other*
☐	☐	*Nitrous Oxide*						
☐	☐	*Other*						

Are you under a physician's care? **Yes** ☐ **No** ☐

Reason?

NUTRITION & LIFESTYLE, Part 7

What is your diet rating?

- ☐ *Good*
- ☐ *Fair*
- ☐ *Poor*

Height_____/Weight_____

Yes	No		Yes	No	
☐	☐	*Eating disorders*	☐	☐	*Do NOT exercise regularly*
☐	☐	*Taking dietary supplements*	☐	☐	*Lemon sucking*
☐	☐	*Drinking carbonated /sweetened beverages*	☐	☐	*Use gum, cough drops or breath mints regularly*
☐	☐	*Frequent snacking or eating*	☐	☐	*High refined carbohydrate consumption*

☐ *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	
☐	☐	*Women: Two or more drinks per day average*	☐	☐	*Current use of smokeless tobacco- Type:_____*	☐	☐	*Recreational drugs*
☐	☐	*Men: Three or more drinks per day average*			*Amount per day?_____*	☐	☐	*Chronic exposure to 2nd hand smoke?*
☐	☐	*Current smoker: Packs a day? _____*	☐	☐	*Former user: When did you quit? _____*	☐	☐	*Interested in quitting*
☐	☐	*Former smoker: When did you quit? _____*						

Additional Notes: