PERSONAL INFORMATION

1. ABOUT YOU

Date

Patient Name

I prefer to be addressed as

(please check) ☐ Male ☐ Female | ☐ Child | ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Domestic Partnered

Home Address

City, Zip

Cell No.

Home No. Work No. Ext.

May we contact you at this work phone? ☐ Yes ☐ No

Email address(es)

How would you prefer to be reminded of appointments? ☐ E-mail or ☐ Phone (indicate preferred number to call)

Date of Birth

Drivers License No.

(note, we cannot take checks from those who do not provide their Drivers License No.)

Employer

Occupation

Other family and household members at Very Nice Smile Dentistry

Check all the ways you have heard about us

☐ Previous Patient ☐ Phone Book ☐ Sign ☐ Postcard / mail

☐ Very Nice Smile Website

☐ Referral from another dentist/patient/staff

Referral's dentist/patient/staff Name

2. SPOUSE/EMERGENCY INFO

Spouse/Partner

Employer

Cell No.

Work No. Ext.

Date of Birth

In the event of an emergency, is there someone other than a spouse you would like us to contact?

Name

Relation

Home No.

Cell No.

Work No. Ext.

3. FINANCIAL INFO

If other than yourself, please list the person responsible for the account and their information below

Name

Social Security No.

Billing Address

Home No.

Work No. Ext.

Relationship to patient

Employer Name

4. INSURANCE INFO

Primary Dental Coverage Insurance Co.

Insured's Name

Date of Birth

Member ID No.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 30 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account. A service charge of 1.5% per month (18% APR) will be added to overdue accounts.

We reserve the right to charge for any appointment cancelled without 24 hours notice.

Signature Date

DENTAL INFORMATION

1. MEETING PATIENT'S IMMEDIATE NEEDS

Patient Name

What brings you here today? ☐ Check-up Time ☐ Problem ☐ Other (explain)

Why are you changing dental offices? ☐ Insurance ☐ Location ☐ Didn't Like

☐ Other (explain)

Do you have problems with your teeth now? ☐ Yes ☐ No

If Yes (check) ☐ Hot ☐ Cold ☐ Sweet ☐ Food-Caught ☐ Broken Tooth ☐ Other

2. PAST DENTAL HISTORY

When was the last time you saw a dentist? ☐ 1st visit ☐ 6 mo. ☐ 1 yr. ☐ 2 yrs. ☐ 3+ yrs.

Former Dentist

Clinic-Location

Phone No.

Last Visit

What treatment did you receive? ☐ Cleaning ☐ Basic Fillings ☐ Major Restoration

Was that a comfortable experience? ☐ Yes ☐ No

Why?

Did you have any treatment that was recommended but not yet completed? ☐ Yes ☐ No

If yes

3. HOME CARE & PERIO HISTORY

What do you do at home to take care of your oral health?

☐ Brush; How often _____ ☐ Floss; How often _____ Mouthwash ☐ Yes ☐ No

Any bleeding when you brush or floss your teeth? ☐ Yes ☐ No

Concerned about (check) ☐ Bad Breath ☐ Taste

☐ Other (explain)

4. COSMETIC

Are you happy with your smile? ☐ Yes ☐ No

Anything you would like to change if you could? ☐ Color ☐ Shape ☐ Position

☐ Detail (if needed)

5. FEARS OR ANXIETIES

Is there anything you don't like about dental appointments?

☐ Discomfort ☐ Fee ☐ Time Inconvenience ☐ Afraid ☐ Other (explain)

6. LIFETIME SMILE PLAN

The way we practice dentistry is something we call "Lifetime Smile Plan." What that means is that we provide you with enough education about the health of your mouth so that you can make choices for yourself. This allows you to save your teeth for the rest of your life, while being happy about the way they LOOK and FEEL.

We are going to teach you about what is HEALTHY and UNHEALTHY, and we will provide you with the alternatives to treating the unhealthy areas. We will inform you of the risks, advantages and disadvantages of treating or not treating your teeth as well. One of the alternatives will always be "TO DO NOTHING." We will always inform you of your costs and what you can expect from your insurance before you schedule your treatment, so there will never be any surprise.

Other Comments

Very Nice Smile
RICHARD C. PIOTROWSKI, DDS

HEALTH INFORMATION

1. HEALTH HISTORY

Today's Date

Patient Name

Patient Date of Birth

Personal Physician

Clinic-Location

Phone No.

Please list any medications you are currently taking (include over the counter medicines)

Medications	Reasons

Are you currently taking birth control pills? ☐ Yes ☐ No

Have you ever taken osteoporosis treatment drugs? ☐ Yes ☐ No

2. ALLERGIES

Please circle if you have any allergies to the following:

Amoxicillin	Aspirin	Erythromycin	Metals / Jewelry	Sulfa
Anesthetics	Codeine	Latex	Penicillin	Tetracycline

Other (explain)

(If any circled) please describe symptoms:

3. CONDITIONS

Please circle if you have ever had any of the following diseases or medical conditions.

Alzheimer's / Memory Loss
Anemia
Anorexia / Bulimia
Arthritis
Artificial Joints (Date_____)
Artificial Heart Valves
Asthma / Hay Fever
Blood Transfusions
Cancer / Chemotherapy
Cold Sores / Herpes
Congenital Heart Defect
Diabetes
Difficulty Breathing
Drug / Alcohol Abuse
Emphysema
Epilepsy / Seizures / Fainting
Gastrointestinal Disorder / Acid Reflux
Glaucoma (Narrow Angle)
Headaches (Severe, Frequent)
Hearing Impaired
Heart Attack
Heart Murmur
Heart Surgery
Hemophilia / Abnormal Bleeding
Hepatitis A B C D
High / Low Blood Pressure
HIV / AIDS
Liver Disease
Kidney Problems
Migraines
Mitral Valve Prolapse
Pacemaker
Radiation Treatments
Rheumatic / Scarlet Fever
Shingles
Smoking / Tobacco
Sinus Problems
Stents Placed in Heart (Date_____)
Stroke
Snoring / Sleep Apnea
Thyroid problems
Tuberculosis
Tumor Growth
Venereal Disease
Other / Surgeries

Have you ever been told you need antibiotics before a dentist appointment? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

Are you currently nursing? ☐ Yes ☐ No

I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.
I hereby certify that the information I have given here today is correct to the best of my knowledge and that payment is due in full at the time of treatment unless prior arrangements have been approved. Furthermore I understand that a 24 hour notice is required to change appointments.

Signature Date