DESIGNING SOLUTIONS for BEAUTIFUL SMILES

ANDREW RUTMAN D.D.S. General & Cosmetic Dentistry

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We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Patient Name:

Last_____ First_____ MI_____

Sex: ☐ Male ☐ Female Date of Birth_____/_____/_____

Soc. Sec.#_____-_____-_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Home Address:_____

City:_____ State:_____ Zip_____

Home Phone #:_____

Patient Employed By:_____

Business Phone #:_____

Business Address:_____

In Case of Emergency--Who should be notified?

Name:_____ Phone #:_____

How did you hear about our office?_____

What specific information about our office made you call and set up an appointment?_____

_____

RESPONSIBLE PARTY INFORMATION

COMPLETE ONLY IF IT IS NOT THE PATIENT

Last_____ First_____ MI_____

Sex: ☐ Male ☐ Female Date of Birth_____/_____/_____

Soc. Sec.#_____-_____-_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Home Address:_____

City:_____ State:_____ Zip_____

Home Phone #:_____

Relationship to the Patient:_____

Employed By:_____

Business Phone #:_____

Business Address:_____

PRIMARY DENTAL INSURANCE

Employee's Name:

Last_____ First_____ MI_____

Employee's Date of Birth:_____/_____/_____

Employee's Soc. Sec. #:_____-_____-_____

Insurance Company Name:_____

Insurance Company Address:_____

Group #:_____

ID# or Subscriber #:_____

SECONDARY DENTAL INSURANCE

Employee's Name:

Last_____ First_____ MI_____

Employee's Date of Birth:_____/_____/_____

Employee's Soc. Sec. #:_____-_____-_____

Insurance Company Name:_____

Insurance Company Address:_____

Group #:_____

ID# or Subscriber #:_____

MEDICAL HISTORY

Physician's Name_____ Date of last visit_____

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

AIDS . . . . . ☐ YES ☐ NO
Anemia . . . . . ☐ YES ☐ NO
Arthritis, Rheumatism . . . ☐ YES ☐ NO
Artificial Heart Valves . . . ☐ YES ☐ NO
Artificial Joints . . . . . ☐ YES ☐ NO
Asthma . . . . . ☐ YES ☐ NO
Back Problems . . . . . ☐ YES ☐ NO
Bleeding Abnormally, with extractions or surgery ☐ YES ☐ NO
Blood Disease . . . . . ☐ YES ☐ NO
Cancer . . . . . ☐ YES ☐ NO
Chemical Dependency . . ☐ YES ☐ NO
Chemotherapy . . . . . ☐ YES ☐ NO
Circulatory Problems . . . ☐ YES ☐ NO
Congenital Heart Lesions ☐ YES ☐ NO
Cortisone Treatments . . . ☐ YES ☐ NO
Cough, persistent or bloody . . . . ☐ YES ☐ NO
Diabetes . . . . . ☐ YES ☐ NO
Emphysema . . . . . ☐ YES ☐ NO
Do you wear contact lenses? . . . . . ☐ YES ☐ NO

Epilepsy . . . . . ☐ YES ☐ NO
Fainting or dizziness . . . . . ☐ YES ☐ NO
Glaucoma . . . . . ☐ YES ☐ NO
Headaches . . . . . ☐ YES ☐ NO
Heart Murmur . . . . . ☐ YES ☐ NO
Heart Problems . . . . . ☐ YES ☐ NO
Hepatitis Type_____ . . . . . ☐ YES ☐ NO
Herpes . . . . . ☐ YES ☐ NO
High Blood Pressure . . . . . ☐ YES ☐ NO
HIV Positive . . . . . ☐ YES ☐ NO
Jaundice . . . . . ☐ YES ☐ NO
Jaw Pain . . . . . ☐ YES ☐ NO
Kidney Disease . . . . . ☐ YES ☐ NO
Low Blood Pressure . . . . . ☐ YES ☐ NO
Mitral Valve Prolapse . . . . ☐ YES ☐ NO
Nervous Problems . . . . . ☐ YES ☐ NO
Pacemaker . . . . . ☐ YES ☐ NO

Women:
Are you pregnant? . . . . . ☐ YES ☐ NO
Due date_____

Are you nursing? . . . . . ☐ YES ☐ NO

Psychiatric Care . . . . . ☐ YES ☐ NO
Radiation Treatment . . . . ☐ YES ☐ NO
Respiratory Disease . . . . ☐ YES ☐ NO
Rheumatic Fever . . . . . ☐ YES ☐ NO
Scarlet Fever . . . . . ☐ YES ☐ NO
Shortness of Breath . . . . . ☐ YES ☐ NO
Sinus Trouble . . . . . ☐ YES ☐ NO
Skin Rash . . . . . ☐ YES ☐ NO
Special Diet . . . . . ☐ YES ☐ NO
Stroke . . . . . ☐ YES ☐ NO
Swelling of Feet or Ankles . . . . . ☐ YES ☐ NO
Swollen Neck Glands . . . . ☐ YES ☐ NO
Thyroid Problems . . . . . ☐ YES ☐ NO
Tonsillitis . . . . . ☐ YES ☐ NO
Tuberculosis . . . . . ☐ YES ☐ NO
Tumor or Growth on head or neck . . . . . ☐ YES ☐ NO
Ulcer . . . . . ☐ YES ☐ NO
Venereal Disease . . . . . ☐ YES ☐ NO
Weight Loss, unexplained . . . . . ☐ YES ☐ NO

Other: _____

MEDICATIONS

List medications you are currently taking:(prescription & non-prescription)

_____
_____
_____
_____
_____

Pharmacy Name _____

Phone _____

ALLERGIES

☐ Aspirin
☐ Amoxicillin
☐ Codeine
☐ Erythromycin
☐ Latex
☐ Local Anesthetic
☐ Penicillin
☐ Sulfa
☐ Tylenol
☐ Other_____

DENTAL HISTORY

How long has it been since you last saw a dentist?_____

When was the last time you had your teeth cleaned?_____

What texture of toothbrush do you use?_____

How often do you floss?_____

Do your gums bleed or feel tender? ☐ YES ☐ NO

Do you clench or grind your teeth? ☐ YES ☐ NO

Do you have any swelling or bumps in your mouth? ☐ YES ☐ NO

Are any of your teeth sensitive to hot, cold, pressure, or sweets? ☐ YES ☐ NO

Have you ever worn braces? ☐ YES ☐ NO
If "yes", when?_____

Are you happy with the overall appearance of your teeth? ☐ YES ☐ NO

Do you have any discolored teeth that bother you? ☐ YES ☐ NO

Would you like your smile to look better? ☐ YES ☐ NO

Would you like straighter teeth? ☐ YES ☐ NO

Have you had any major dental procedures performed? ☐ YES ☐ NO
If "yes", when?_____

Are you apprehensive about dental treatment? ☐ YES ☐ NO

Have you had any complications with any dental procedure? ☐ YES ☐ NO
If "yes", list complications:_____

Do you smoke cigarettes, pipes, or cigars? ☐ YES ☐ NO

INSURANCE

To avoid misunderstanding regarding dental insurance, all professional services rendered are charged directly to the patient and that the patients are personally responsible for payments of fees. We will prepare necessary forms or reports to help you obtain benefits from your insurance company. We do not render our services on the basis that insurance companies will pay all our fees. All fees are individual for the individual patient.

Signature: Parent or Guardian

✖_____

Print Name:_____

Date:_____

APPOINTMENTS

A minimum charge will be made for failed or cancelled appointments without prior notification of 24hrs. This fee covers a portion of the overhead which still has to be paid whether you are present or not.

Initial_____