



The benefits of a happy, healthy smile are immeasurable!
Our goal is to help you reach and maintain maximum oral health.
Please fill out this form completely, so we may serve you better.

1 ABOUT YOU

Today's Date _____

Name: _____
LAST FIRST MI MR MRS MS DR.

I prefer to be called: _____ Male Female

If child, parents name: _____

Birthdate: _____ Age: ____ SS #: _____

Home address: _____

City/State/Zip: _____

Email address: _____

Single Married Divorced Widowed Separated

Home #: _____

Wk #: _____ Ext: _____

Cell #: _____

Employer: _____

Employer's address: _____

City/State/Zip: _____

Occupation: _____

How long there? _____

Where & when are best times to reach you? _____

Who may we Thank for referring you? _____

Purpose of this appointment? _____

2 SPOUSE INFORMATION

Spouse Name: _____ Birthdate: _____

Employer: _____ Occupation: _____

Address: _____

City/State/Zip: _____

Wk #: _____ Ext: ____ SS #: _____

Cell #: _____

Person Responsible for Account: _____

If patient is responsible party, please check this box and go on to Section 3.

Wk #: _____ Ext: ____ Hm #: _____

Billing Address: _____

City/State/Zip: _____

Relationship: _____ SS #: _____

Employer: _____ Birthdate: _____

3 DENTAL INSURANCE

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Phone #: _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: _____ Insured's SS #: _____

Insured's Employer: _____
IF RETIRED, USE LAST EMPLOYER

Address: _____

City/State/Zip _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Phone #: _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: _____ Insured's SS #: _____

Insured's Employer: _____
IF RETIRED, USE LAST EMPLOYER

Address: _____

City/State/Zip _____

I authorize the release of information necessary for the processing of insurance claims and assign benefits to Dr. Charles C. Clausen, D.D.S., P.C.

Signature: _____

In case of emergency, whom should be notified? _____

Phone #: _____

4 FINANCIAL RESPONSIBILITY

I acknowledge that I am responsible for all charges for services provided, including any amount not paid by my insurance plan. If collection procedures become necessary I agree to pay all attorney and collection fees.

I acknowledge I have received a copy of this office's Notice of Privacy Practices.

I also authorize the release of all dental information necessary for processing insurance claims to my insurers or any third party or their agents.

I understand that 48 business hours notice for cancellations is required or I may be subject to a \$75 service fee.

PATIENT/INSURED SIGNATURE

DATE

5 MEDICAL / DENTAL HISTORY

Physician's Name: _____

Phone #: _____ Date of last visit: _____

Height: _____ Weight: _____ Blood Pressure: _____

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? No Yes

Please explain: _____

Are you taking any medications? No Yes

Are you taking any herbal supplements? No Yes

Please list each one: _____

When was your last dental appointment? _____

When was your last full mouth X-Ray taken? _____

Where? _____

For Women: Are you taking any birth control pills? No Yes

Are you pregnant? No Yes Week #: _____

Are you nursing? No Yes

Do you have or have you ever had:

Blood Transfusion No Yes

Severe/Frequent headaches No Yes

Pain in or near your ears No Yes

Growth or sore spots in your mouth No Yes

Mouth hurts when clenched..... No Yes

Gums bleed No Yes

Do you at the present time have any dental complaints .. No Yes

Do you habitually clench your teeth during the night or day. No Yes

Any part of your mouth sore to pressures or irritants (cold, sweets, etc.)..... No Yes

Do you use tobacco products..... No Yes

Are you allergic to:

Penicillin..... No Yes

Local anesthetic..... No Yes

Other medications or drugs: _____

Have you been hospitalized in the last 5 years?..... No Yes

If so, for what _____

6 MEDICAL / DENTAL HISTORY Cont.

Do you take aspirin? No Yes

Do you take blood thinners? No Yes

Do you take bisphosphonates?..... No Yes

Do you have or have you ever had:

HIV Positive No Yes

Anemia No Yes

Asthma No Yes

Diabetes No Yes

Epilepsy No Yes

Hepatitis..... No Yes

Rheumatic Fever No Yes

Artificial Joints No Yes

Heart Murmur No Yes

Mitral Valve Prolapse..... No Yes

Abnormal Heart Condition No Yes

Abnormal Bleeding From A Cut..... No Yes

Abnormal Blood Pressure No Yes

Respiratory Disease No Yes

Pulmonary Shunts No Yes

Rheumatism or Arthritis No Yes

Tumors or Growths..... No Yes

Any Blood Disease No Yes

Any Liver Disease No Yes

Any Kidney Disease No Yes

Any Stomach or Intestinal Disease No Yes

Any Venereal Disease No Yes

7 APPEARANCE SATISFACTION

Are you satisfied with the appearance of your teeth? No Yes

If NO, what concerns do you have about the appearance of your teeth?

What changes, if any, would you like to make to your smile? _____
