Patient Information

Howard B. Dean, D.D.S.
Imagine…a great smile…
renewed health
1251 Nilles Road, Suite 9
Fairfield, Ohio 45014
513-829-2026

Date: _____

Patient's Name _____ Date of Birth _____

Circle One: Single Married Widowed Divorced Separated

Address _____ City_____ State_____ Zip_____

Home Phone _____Business Phone_____ Cell Phone_____

Social Security # _____ Email _____

Employer _____ Occupation_____

Employer's Address_____

Name of Responsible Party for Account _____Relationship_____

Notify in case of emergency _____Phone_____

Whom may we thank for this referral? _____

For patient with dental benefits only (please present benefits card)

Benefits Company_____ Subscriber Name_____

Subscriber Social Security #_____Subscriber Date of Birth_____

Subscriber Employer_____ Work Phone_____

Address to mail claims_____

AUTHORIZATION

To the best of my knowledge all the preceding answers are true and correct. I authorize the benefit company indicated on this form to pay to the dentist all benefits otherwise payable to me for services rendered. I authorize the use of this signature on all benefit claims submissions. I authorize Dr. Dean to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by dental benefits.

Patient (Responsible party) Signature _____Date_____

Dental History

These are things important to me about my dental health (please circle one)

Truthful answers to the following questions will allow us to treat you on a more individualized basis, providing the care appropriate for your particular needs. As before, your answers are for our records only and will be considered confidential.

My mouth is	***a***. very comfortable ***b***. moderately comfortable ***c***. uncomfortable	I think my present state of dental health is:	***a***. excellent b. good c. poor
I	***a***. think the appearance of my mouth is excellent ***b***. am satisfied with the appearance of my mouth ***c***. am dissatisfied with the appearance of my mouth	My goal is to have my mouth in:	a. excellent health b. good health c. poor health
I	***a***. will do anything to keep my natural teeth ***b***. want to keep my teeth but have a certain budget of time and money that I am willing to spend on them ***c***. don't care whether I keep my teeth or not	I	a. have always done the best that was recommended for my dental health b. have not done what dentists have recommended for me c. rarely go and don't care much about having my dental work completed
I	***a***. have set goals for my oral health with a previous dentist ***b***. want to set goals concerning my dental health ***c***. never set goals concerning my dental health	I	a. put dentistry for myself and family high on my priority list b. put dentistry for myself and family low on my priority list c. dentistry is on my list but hard to find

What is/are your primary dental concerns? _____

Are you having any dental pain or discomfort at this time? Yes No

Have you ever had a bad experience in a dental office? Yes No

Does dental treatment make you nervous? No Slightly Moderately Extremely

Date of last dental visit :_____ Date of last dental x-rays: _____

Circle yes (Y) or no (N) if you have had problems with any of the following:

Y	N	Bad breath	Y	N	Loose teeth or broken fillings
Y	N	Bleeding gums	Y	N	Sensitivity to cold
Y	N	Clicking or popping jaw	Y	N	Sensitivity to hot
Y	N	Food collection between teeth	Y	N	Sensitivity to sweets
Y	N	Grinding or clenching teeth	Y	N	Sensitivity when biting
Y	N	Orthodontic treatment (braces)	Y	N	Sores or growths in mouth
Y	N	Periodontal treatment			

How often do you brush? _____ floss? _____

What are some questions about dentistry and oral health that you have never had adequately answered for you?

_____

_____

Medical Questionnaire

Correct answers to the following questions will allow me to treat you so there ***WILL NOT*** be an emergency. However, if an emergency situation does arise, this information will help ensure proper treatment. As before, your answers are for our records only and will be considered confidential.

Check any of the following which you have had, or have at present

____ Abnormal bleeding from a cut
____ Abnormal blood pressure
____ Abnormal heart condition
____ AIDS/HIV
____ Allergies/Hives (list below)
____ Anemia
____ Arthritis
____ Artificial joints
____ Asthma/respiratory problems
____ Crohn's disease
____ Cancer/tumors
____ Diabetes
____ Emotional stress
____ Epilepsy
____ Fibromyalgia
____ Frequent headaches
____ Glaucoma
____ Heart disease/murmur/valve problems
____ Hepatitis Type____
____ Kidney/liver disease
____ Osteoporosis
____ Radiation treatment
____ Rheumatic fever
____ Substance abuse/drug/alcohol
____ Swelling of feet or ankles
____ Thyroid problems
____ Tobacco habit
____ Tuberculosis

Physician's name, address, phone_____

Date of last visit _____ Have you had any serious illnesses or operations? Yes No

Are you under a physician's care right now? Yes No

Have you taken any drugs, medications or pills within the last two months? If so, please list below

_____

_____

Please list any allergies_____

Do you have sleep disorder/apnea/snoring problems? Yes No

Women only Are you pregnant or think you may be? Yes No
Are you taking birth control pills? Yes No

Do you have any disease, condition, or problem not listed? Yes _____

AUTHORIZATION

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by Dr. Dean to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform Dr. Dean. I consent to the use of my x-rays, records and/or photos for scientific publication/teaching purposes provided my name remains anonymous.

Patient (Responsible party) Signature _____***Date***_____