LARRY PICARD | DDS

Getting to Know You

Name _____ **date** _____

What name would you like us to call you? _____

Please describe the reason for your consultation today _____

_____

_____

How long has this been going on and what other events apply to today's visit? _____

_____

Why have you decided to deal with this now? _____

_____

Have you consulted with any other dentist about this? **YES** **NO** *if Yes, what was discussed or done?*

_____

_____

When was your last dental check up? _____

Who is your regular or previous dentist? _____

Have you noticed or has any dentist or hygienist ever said that you *(please circle all that apply)*

Have gum disease (gingivitis)	**YES**	**NO**	Lip or cheek bleeding	**YES**	**NO**
Grind your teeth	**YES**	**NO**	Loose or broken teeth or fillings	**YES**	**NO**
Clicking or popping jaw	**YES**	**NO**	Food collection between teeth	**YES**	**NO**
Jaw pain or tiredness	**YES**	**NO**	Sores, blisters or growths	**YES**	**NO**
Pain around ear	**YES**	**NO**	Bad breath	**YES**	**NO**

Sensitivity to cold heat sweets when biting or chewing

Would you like to know your options to improve your smile look younger keep your teeth

What are your priorities and what would you like to see done now?

_____

_____

We always welcome your friends and family

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Personal Information & Health History

Name _____ **birth date** _____ **Social Security No** _____

Mailing address _____ **City** _____ **State** _____ **Zip** _____

work _____ **home** _____ **cell** _____ **fax** _____

pager _____ **email** _____ **Marital Status** __ single __ married __ divorced __ widowed

How or who referred you to our office? _____

Occupation _____ **Employer & address** _____

Spouse's occupation _____ **Employer & address** _____

Account responsibility (if someone other than yourself)

Name _____ **birth date** _____ **Social Security No** _____

Mailing address _____ **daytime phone** _____

INSURANCE: If you have dental insurance, we will provide you with receipt documentation that can be attached to your insurance company form for proper filing. You will receive a reimbursement directly for whatever you are entitled to. The most important thing for you to know is the amount of your "calendar year maximum" which you can find by calling your insurance carrier.

Health History (please circle "yes" or "no", if you have or had any of the following)

YES	NO	Are you in good health?	YES	NO	TB, asthma or lung disease
YES	NO	Has your health changed in the last year	YES	NO	Diabetes
YES	NO	Chest pain, shortness of breath	YES	NO	Tumors, cancer
YES	NO	Bleeding problems, bruise easily	YES	NO	Radiation treatment
YES	NO	Headaches, ringing in ears	YES	NO	Psychiatric care
YES	NO	Joint pain or stiffness, arthritis	YES	NO	Kidney or bladder disease
YES	NO	Fainting or seizures	YES	NO	VD, herpes
YES	NO	Heart disease, murmurs, rheumatic fever, prosthetic heart valve	YES	NO	HIV positive, AIDS, ARC
YES	NO	Pacemaker	YES	NO	Pregnant month _____
YES	NO	High Blood pressure	YES	NO	Birth control pills
YES	NO	Hepatitis or liver disease	YES	NO	Recreational drugs smoking/alcohol

List any and all ALLERGIES _____

List any and all DRUGS/MEDICATIONS you are taking _____

List any and all SURGERIES _____

Are you being treated by a Doctor now? YES NO Who? _____

The above information is true and correct to the best of my knowledge.

PATIENT SIGNATURE _____ **DATE** _____

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