**Welcome to Goetz Dental! Please take a few minutes to answer the following questions below so we may better assist you with your health care needs.**

GOETZ FAMILY DENTAL

## PATIENT INFORMATION

Date : _____ Soc. Sec. # : _____ Birth date : _____

Last Name : _____ First Name : _____ Initial : _____

Address : _____ Cell : _____ Home Phone: _____

City : _____ State : _____ Zip : _____

Sex : ☐ M ☐ F

☐ Minor ☐ Single ☐ Married ☐ Long Term Partner ☐ Divorced ☐ Widowed ☐ Separated

Employer : _____ Business Phone : _____

Business Address : _____ Occupation : _____

Who should we thank for referring you? _____

In case of emergency, who should we contact? _____ Phone : _____

## PRIMARY INSURANCE

**Person Responsible for Account:**

Last Name: _____ First Name: _____ Initial: _____

Relationship to Patient: _____ Birth date : _____ Soc. Sec # : _____

Address: _____ Cell: _____ Home Phone: _____

City: _____ State : _____ Zip : _____

Responsible Party Employed By: _____ Business Phone : _____

Business Address: _____ Occupation: _____

Insurance Company: _____

Insurance Company Address: _____

Subscriber I.D.#: _____ Group #: _____

## ADDITIONAL INSURANCE

**Insured Name:**

Last Name : _____ First Name : _____ Initial : _____

Relationship to Patient : _____ Birth date : _____ Soc. Sec # : _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip : _____

Insured Employed By : _____ Business Phone : _____

Insurance Company : _____

Insurance Company Address : _____

Subscriber I.D.#: _____ Group #: _____

# HEALTH HISTORY

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs.

Name: _____ Birth date : _____ Age : _____

Why are you now seeking dental treatment? _____

Please answer each question. Check YES or NO. If in doubt, leave blank

| | | Yes | No |
|---|---|---|---|
| 1. | Are you in good health now? | ☐ | ☐ |
| 2. | Are you now under the care of physician? | ☐ | ☐ |
| | If so, what is the condition being treated? _____ | | |
| 3. | Have you ever been hospitalized or had a serious illness? | ☐ | ☐ |
| | If yes, explain _____ | | |
| 4. | Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal now than previously? | ☐ | ☐ |
| 5. | (Woman) Are you pregnant? If so, give due date _____ | ☐ | ☐ |
| 6. | Do you use tobacco in any form? If yes, how much _____ | ☐ | ☐ |
| 7. | Do you use alcoholic beverages (more than 2 drinks per day) ? | ☐ | ☐ |

8. Do you have or have you ever had any of the following?

## GENERAL

| | YES | NO |
|---|---|---|
| Tire easily, weakness | ☐ | ☐ |
| Marked weight change | ☐ | ☐ |
| Night sweats | ☐ | ☐ |
| Persistent fever | ☐ | ☐ |
| **SKIN** | | |
| Eruptions (rash) hives | ☐ | ☐ |
| Change color skin color | ☐ | ☐ |
| **EYES** | | |
| Visual change | ☐ | ☐ |
| Glaucoma | ☐ | ☐ |
| **EARS** | | |
| Loss of hearing | ☐ | ☐ |
| Ringing in ears | ☐ | ☐ |
| **NOSE** | | |
| Frequent nosebleeds | ☐ | ☐ |
| Sinus problems | ☐ | ☐ |
| **THROAT** | | |
| Soreness/hoarseness | ☐ | ☐ |
| **NERVOUS SYSTEM** | | |
| Stroke | ☐ | ☐ |
| Headaches | ☐ | ☐ |
| Convulsions / epilepsy | ☐ | ☐ |
| Numbness / tingling | ☐ | ☐ |
| Dizziness / fainting | ☐ | ☐ |
| Psychiatric treatment | ☐ | ☐ |
| **RESPIRATORY** | | |
| Tuberculosis | ☐ | ☐ |
| Emphysema | ☐ | ☐ |
| Asthma / hay fever | ☐ | ☐ |
| Persistent cough | ☐ | ☐ |
| Sputum production (phlegm) | ☐ | ☐ |
| Cough up bloody sputum | ☐ | ☐ |
| Difficulty breathing while lying down | ☐ | ☐ |
| **ENDOCRINE** | | |
| Diabetes | ☐ | ☐ |
| Family history of diabetes | ☐ | ☐ |
| Thyroid condition/goiter | ☐ | ☐ |
| Other | ☐ | ☐ |

## HEART/BLOOD VESSELS

| | YES | NO |
|---|---|---|
| Rheumatic fever | ☐ | ☐ |
| Heart murmur | ☐ | ☐ |
| Chest pain/discomfort | ☐ | ☐ |
| Heart attack/trouble | ☐ | ☐ |
| Shortness of breath | ☐ | ☐ |
| Swelling of ankles | ☐ | ☐ |
| High Blood pressure | ☐ | ☐ |
| Congenital heart disease | ☐ | ☐ |
| Mitral valve prolapsed | ☐ | ☐ |
| Artificial heart valve | ☐ | ☐ |
| Pacemaker | ☐ | ☐ |
| Heart surgery | ☐ | ☐ |
| Other | ☐ | ☐ |
| **BONE/MUSCLES** | | |
| Arthritis/rheumatism | ☐ | ☐ |
| Artificial joints/limbs | ☐ | ☐ |
| **DIGESTIVE SYSTEM** | | |
| Hepatitis | ☐ | ☐ |
| Jaundice | ☐ | ☐ |
| Ulcers | ☐ | ☐ |
| Change in appetite | ☐ | ☐ |
| Black, bloody or pale stools | ☐ | ☐ |
| **UNIRARY** | | |
| Kidney disease | ☐ | ☐ |
| Increase in frequency of urination (night) | ☐ | ☐ |
| Burning on urination | ☐ | ☐ |
| Urethral discharge | ☐ | ☐ |
| Bloody urine | ☐ | ☐ |
| Venereal disease | ☐ | ☐ |
| **BLOOD** | | |
| Bruise easily | ☐ | ☐ |
| Anemia | ☐ | ☐ |
| Blood transfusion | ☐ | ☐ |
| **OTHER** | | |
| Radiation therapy | ☐ | ☐ |
| Chemotherapy | ☐ | ☐ |
| Tumors or growths | ☐ | ☐ |
| Cancer | ☐ | ☐ |
| HIV+ | ☐ | ☐ |
| AIDS | ☐ | ☐ |

*Please complete reverse side*

9. Are you ALLERGIC or have you experienced any reaction to the following?

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Local anesthetics ( e.g. novocaine)..... | ☐ | ☐ | Aspirin or codeine ..... | ☐ | ☐ |
| Barbiturates/sedatives/sleeping pills ..... | ☐ | ☐ | Sulfa drugs ..... | ☐ | ☐ |
| Penicillin/other antibiotics ..... | ☐ | ☐ | Other allergies _____ | | |

10. Are you taking any of the following?

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Antibiotics/sulfa drugs ..... | ☐ | ☐ | Tranquilizers ..... | ☐ | ☐ |
| Blood thinners ..... | ☐ | ☐ | Insulin/other diabetes drugs ..... | ☐ | ☐ |
| Blood pressure medication ..... | ☐ | ☐ | Recreational drugs ..... | ☐ | ☐ |
| Thyroid medicine ..... | ☐ | ☐ | Digitalis/others heart medications ..... | ☐ | ☐ |
| Cortisone/steroids ..... | ☐ | ☐ | Nitroglycerin ..... | ☐ | ☐ |
| Antihistamines/allergy drugs/cold remedies ..... | ☐ | ☐ | Aspirin ..... | ☐ | ☐ |
| | | | Other medication _____ | | |

If yes to any of the above, list ***name*** of medication and ***dosage*** below:

1. _____
2. _____
3. _____
4. _____

11. Is there any disease, condition or problem not listed that you think we should know about, or is there any activity your doctor says you cannot do? If so, explain _____
_____

12. Physician's Name _____ Phone _____
13. Have you ever had any serious trouble associated with previous dental treatment? _____
_____

14. Does dental treatment make you nervous? No _____Slightly_____Moderately_____Extremely_____
15. Date of last dental visit _____
16. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? _____
If so, when? _____
17. Do you have or have you ever had any of the following?

**MOUTH**

| | YES | NO |
|---|---|---|
| Bleeding, sore gums ..... | ☐ | ☐ |
| Unpleasant taste/bad breath ..... | ☐ | ☐ |
| Burning tongue/lips ..... | ☐ | ☐ |
| Frequent blisters, lips/mouth ..... | ☐ | ☐ |
| Swelling/lumps in mouth ..... | ☐ | ☐ |
| Ortho treatment (braces) ..... | ☐ | ☐ |
| Biting cheeks/lips ..... | ☐ | ☐ |
| Clicking/popping jaws ..... | ☐ | ☐ |
| Difficulty opening or closing jaw ..... | ☐ | ☐ |

**TEETH**

| | YES | NO |
|---|---|---|
| Loose teeth ..... | ☐ | ☐ |
| Sensitive to hot ..... | ☐ | ☐ |
| Sensitive to cold ..... | ☐ | ☐ |
| Sensitive to sweets ..... | ☐ | ☐ |
| Sensitive to biting ..... | ☐ | ☐ |
| Food impaction ..... | ☐ | ☐ |
| Clenching/grinding ..... | ☐ | ☐ |
| Shifting of teeth ..... | ☐ | ☐ |
| Change in bite ..... | ☐ | ☐ |

## ORAL HYGIENE

**Do you use the following?**

| | YES | NO |
|---|---|---|
| Brush ..... | ☐ | ☐ |
| Dental floss ..... | ☐ | ☐ |
| Fluoride rinse ..... | ☐ | ☐ |
| Other _____ | | |

How often do you brush _____

Brush is: Soft☐ Medium☐ Hard ☐

To the best of my knowledge, all of the preceding answers are true and correct.

If I ever any change in my health or change in my medication, I will inform the dentist at the next appointment.

Signature of Patient
Parent or Guardian _____ Date _____

# FINANCIAL POLICY

This statement is to inform you of our financial policy. We are committed to providing you with the highest quality dental care using only the best materials and technology available. We are also committed to providing you with up-to-date information and educational tools so that we may assist you in maintaining optimum oral health. Our financial policy is intended to facilitate excellent service to you while minimizing our administrative costs.

Payment is expected at the time of service. If you have dental insurance you estimated co-pay is also expected. We accept cash, personal checks, and all major credit cards. Outside financing is available through Care Credit.

If your account is turned over to our collection agency then you will be responsible for a 15% collection fee, and finance charges of 1.5% (18%APR) on account balances over 90 days old. Our office charges a fee of $50.00 for ALL failed (broken) appointments. Three failed appointments may result in dismissal from the practice.

| _____ | _____ | _____ |
|---|---|---|
| Print Name | Signature | Date |

# ASSIGNMENT OF BENEFITS

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not your insurance company. If your dental insurance denies a claim, the balance is your responsibility. As a courtesy to you we will help you process all insurance claims. You may direct your insurance company to pay your benefits directly to our office by signing the authorization below.

I have read and understood the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to Goetz Family Dental.

| _____ | _____ | _____ |
|---|---|---|
| Print name | Signature | Date |

# GOETZ FAMILY DENTAL

Sean H. Goetz, DDS

I hereby authorize the release of my dental records to:

Goetz Family Dental

Sean H. Goetz, DDS

670 Boston Post Rd.

Old Saybrook, CT 06475

goetzfamilydental@gmail.com

NAME_____

ADDRESS_____

_____

DOB_____

SIGNATURE_____

DATE_____