DAN DRAKE, DDS & ASSOCIATES

Patient Information:

Patient's Name ________________ M F Birthdate ___/___/_____ Age ____ Date ___/___/______

Name you wish us to call you by: ____________ Social Security # _____-____-_______ Spouse's Name: ________________

Home Address: Street: ________________ City: ____________ State _____ Zip: __________

Home Phone: (_____) _______-__________ Work Phone: (_____) ______-__________ Cell Phone: (_____) ______-__________

Email: ________________ Emergency Contact : ________________ Phone: (_____) ______-__________

Patient Employer: ________________ yrs _____ Spouse's Employer: ________________ yrs _____

How did you find our practice? (circle) Patient Family/Friend Internet TV Ad Yellow Pages Newspaper/Mag Ad Sponsorship Other

If patient/family/friend: Who? ____________ What did they say? ________________

Dental Insurance Information:

Subscriber Name: ________________ Date of Birth ___/___/_____ SS# _____-____-_______

Relationship to Patient ____________ Insurance Company: ________________ Policy #: ____________

Medical History and General Health:

Have you had any serious illness or operation? If yes, what? ________________

When was the last time you were in the hospital? __________ For what? ________________

Are you under any medical treatment now? **Y / N** If yes, for what? ________________

Women: Are you pregnant? **Y / N** Taking birth control pills? **Y / N** (if yes, antibiotics may counteract) Hormone therapy? **Y / N**

Are you **allergic** to Penicillin? **Y / N** Any other **allergies**? **Y / N** If yes, what? ________________

Do you have or have you ever had the following? If yes, please check:

☐ Heart Valve Replacement If yes, when? ____ / ____ ☐ Prosthetic Joint Replacement If yes, when? ____ / ____ ☐ Facial Radiation Therapy If yes, when? ____ / ____

☐ High or Low Blood Pressure ____ / ____ If yes, are you taking medication? **Y / N** What? ________________

☐ Anemia or Blood Disorder ☐ Arthritis ☐ Stroke

☐ Hepatitis (Type ____) ☐ Venereal Disease ☐ AIDS, ARC, HIV+

☐ Diabetes Taking Insulin Y / N ☐ Emphysema ☐ Kidney Trouble

☐ Persistent Cough ☐ Jaundice or Liver Disease ☐ Dizziness or Fainting

☐ Tumors or Growth ☐ Asthma, Hayfever or Sinusitis ☐ Tuberculosis

☐ Epilepsy ☐ Convulsions ☐ Drug Addiction

☐ Do you smoke ? ____ Packs / day x ____ years = _____ Pack Yrs ☐ Do you use smokeless Tobacco?

☐ Do you get enough Vitamins? Diet Supplement Both ☐ Do you take daily low dose aspirin?

Medications/purpose: ________________

____

Physician's Name ________________ Phone Number: (_____) _____-_______ Last visit: ____/______

Yes No Is there any disease, condition or health problem not listed above that we should know about? ________________

____

Patient Info provided by (please sign): ________________ Date: ___/______

We endeavor to make your visits as pleasant as possible. Please tell your friends about your positive experiences!
Please fill out "Dental History" on reverse side and sign prior to proceeding with any treatment.

Dental History:

Yes No Do you have any specific dental concerns? Please explain:________________________________

____

Yes No Have you had any serious trouble with or are you unhappy with any previous dental treatment?
If yes, please explain: ____

Previous Dentist Name:______________________________ Last visit _____________ Last x-rays:____________

Yes No Do you have a specific fear of having dental work done? If yes, during dental treatment do you prefer:
Local anesthetic Y / N Nitrous Oxide Y / N Presedation (pill) Y / N IV Sedation Y / N

Yes No Have you been told you have Gingivitis/Periodontis? What year were you first told? _____; last told?_____

Yes No Have you been receiving corrective periodontal scaling (pockets over 4 mm) every ____months?

Yes No Have you been referred to/treated by a Periodontist? When first referred?____ When last treated? ____

Yes No Do your gums bleed? How often do you brush? __ x a week How often do you floss? __ x a week

Yes No Have you noticed an unpleasant taste/odor or any new/increasing spaces between/loosening of teeth?

Yes No Do you chew on only one side of your mouth? Left/Right Does this cause pain? Where?______________

Yes No Have you noticed yourself grinding/clenching your teeth? Does this cause pain? Where? ____________

Yes No Have you been advised you have TMJ (bite/joint) problems? Have you been treated for TMJ? Y / N

Yes No Are any of your teeth sensitive to cold, sweets or chewing/pressure? Where? ____________________

Yes No Do you want brighter teeth? If yes, have you ever bleached your teeth? Was it successful? Y / N

Yes No Are you unhappy with your teeth/smile? Y / N If yes, please complete our "Smile Analysis" form.

Yes No Have you had previous orthodontic treatment? When? _______ Have your teeth shifted? Y / N

Yes No Do you snore or have sleep apnea? If yes, do you wear a CPAP or other appliance? Y / N

Yes No Are you curious about BOTOX® or Juvederm® Fillers to smooth wrinkles?

What can we do to make your visits to our office more pleasant? ____________________________________

PRIORITY LEVEL OF CARE:

We believe it is appropriate for you to have an awareness of your overall Oral Health and the **PRIORITY LEVEL OF CARE** of indicated treatment necessary to improve and maintain your Oral Health.

Priority Level 1 Care: **IMMEDIATE NEED (Crisis Dentistry)**
pain; decay; broken/cracked tooth; broken/cracked/defective filling; periodontal disease

Priority Level 2 Care: **IMPENDING NEED (Need Based Dentistry)**
sensitive/cracked tooth; unsupported enamel; weak/corroded/oversize filling; occlusal wear into dentin

Priority Level 3 Care: **PREVENTIVE/IDEAL/OPTIMAL ORAL HEALTH CARE (Comprehensive Dentistry)**
cracked tooth (visual); craze lines; weak/corroded/oversize/old filling; worn teeth; collapsed occlusion/closed bite

Priority Level 4 Care: **COSMETIC DENTISTRY**
bleaching; recontour; bonding; porcelain veneers/crowns; replace dark fillings; BOTOX®/Dysport® or Juvederm®/Surgiderm®

We recommend completing Level 1 Care immediately and Level 2 Care as soon as possible, planning for completion of Level 3 Comprehensive Care Treatment on a timely basis, and proceeding with Level 4 Cosmetic Treatment if/when desired.

Please read & sign prior to any treatment:
I will not proceed with any treatment until I have all my questions regarding all options (including no treatment), complications, appointments or fees explained to my complete satisfaction. In order to minimize bookkeeping time and eliminate unnecessary fee increases, all fees for professional services are to be paid at time of treatment unless specific financial arrangements are made in advance. If I request an extended payment (plus interest) arrangement, I authorize obtaining Credit Bureau Reports. I authorize the performance of all procedures necessary in executing the treatment of the above named patient including the administration of anesthetics. I authorize the taking of and showing clinical photographs, and I take full responsibility for all financial obligations incurred. I hereby agree to pay any and all costs of collection for any amounts due, including attorney fees. I acknowledge I have received and/or reviewed the notice of privacy practices.

Signature (Guardian if Patient is a Minor):______________________________

Method of Payment: ☐ Check ☐ Cash ☐ VISA/MasterCard/Discover/AmEx ☐ Care Credit

Daniel R. Drake, DDS, MICOI
Member Academy of General Dentistry
Fellow & Master International Congress of Oral Implantology
Certified in Conscious IV Sedation

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