New Patient Forms

Septimiu N Pastiu, DMD
Sewell Dental Arts

DATE:__________

We are committed to excellence in dentistry and appreciate you taking the time to complete this confidential questionnaire. The better we communicate, the better we can care for you. If you have any questions or need assistance, please ask us - we will be happy to help.

Whom may we thank for referring you?

____

ABOUT YOU

Name: ______________________________

I prefer to be called________________ [ ] Male [ ] Female

[ ] Single [ ] Married [ ] Child [ ] Other

Birth date: ___/___/___ Age: _____

S.S. #: ________________________________

Home Address:

____

City______________ State____Zip_________

Home Phone: (____) ________________

Work: (____) ________________ ext. ___

Cell: (____) __________________

E-mail Address:

____

Employer: ______________________________

How long there? ________________ Occupation: ___________________

Employer's Address: ____________________________________

City________________ State_________ Zip___________

PERSON RESPONSIBLE FOR ACCOUNT

[ ] Same as above Name: _________________________________

Birth date:___/___/___ Relation: ______________

Billing Address: ____

City____________State____Zip_________

Home Phone: (____) ________________ Work: (____) ________________

S.S. #: __________________________

Employer: _________________________________

How long there? _________ Occupation:___________________

SPOUSE INFORMATION

[ ] Same as above Name: ____

Birth date: ___/___/___

Employer: ____

Work Phone: (____) ___________ext. _____

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DENTAL INSURANCE INFORMATION

Primary Insurance
Insurance Co. Name: ______________________ Phone: (____) __________
Group/Policy #: ________________ Insured's Name: ____________________
Insured's Birth date: ___/___/___ Relation: ________________
Insured's Social Security #: ______________________________
Insured's Employer: ___________________________

Secondary Insurance
Insurance Co. Name: ______________________ Phone: (____) __________
Group/Policy #: ________________ Insured's Name: ____________________
Insured's Birth date: ___/___/___ Relation: ________________
Insured's Social Security #: ______________________________
Insured's Employer: _______________________

MEDICAL HISTORY INFORMATION

Name of Physician: ____
Phone: (____) ____________________
Do you have or have ever had any of the following? Please check those that apply:

[ ]Allergies/Hay Fever	[ ] Diabetes	Heart Surgery*	[ ] Rheumatic Fever
[ ] Anemia	[ ] Epilepsy or Seizures	[ ] Hepatitis	[ ] Rheumatism
[ ] Angina	[ ] Excessive Thirst	[ ] High Blood Pressure	[ ] Sickle Cell Disease
[ ] Arthritis	[ ] Fainting or Dizziness	[ ] HIV*/AIDS	[ ] Sinus Problems
[ ] Artificial Joints *	[ ] Fever Blisters/Cold Sores	[ ] Kidney Problems	[ ] Stroke
[ ] Artificial Heart Valves *	[ ] Frequent Cough	[ ] Liver Problems	[ ] Surgical Shunt*
[ ] Asthma	[ ] Glaucoma	[ ] Mental Disorders	[ ] Thyroid Problems
[ ] Breathing Problems	[ ] Heart Disorder (Congenital)*	[ ] Mitral Valve Prolapse*	[ ] Tuberculosis
[ ] Cancer	[ ] Heart Infection*	[ ] Osteoporosis	[ ] Ulcers
[ ] Chemical Dependency	[ ] Heart Murmur*	[ ] Radiation Treatment	[ ] Venereal Disease
[ ] Chemotherapy	[ ] Heart Pace Maker*	[ ] Respiratory Problems	[ ] Yellow Jaundice

* This condition may require antibiotic premedication for certain dental procedures.

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YES NO

☐ ☐ Do you have any health problems that were not listed above or need further clarifications?
If yes, explain:

___

☐ ☐ Are you now under the care of a physician?
If yes, explain:

___

☐ ☐ Have you been admitted to a hospital or needed emergency care during the past two years?
If yes, explain:

___

☐ ☐ Are you taking any medications or herbals?
If yes, list:

___

☐ ☐ Are you allergic to any medications or substances?
If yes, please check box below:
[ ] Aspirin [ ] Penicillin [ ] Codeine [ ] Iodine [ ] Metal [ ] Latex [ ] Other

___

☐ ☐ Have you used tobacco?
If yes, explain:

___

WOMEN (Please check): [ ] Pregnant [ ] Trying to get pregnant [ ] Nursing [ ] Taking oral contraceptives

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my
medications change, I will inform the dentist and the staff at the next appointment without fail.

X ______________________________ Date ________________
Signature of patient, parent or guardian

MEDICAL UPDATES

I have read my MEDICAL HISTORY dated ____________ and confirm that it states past and present conditions.

Date:	Exceptions:		Patient's Signature:
_______	______________________	[ ] None	x______________________
_______	______________________	[ ] None	x______________________
_______	______________________	[ ] None	x______________________

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DENTAL HEALTH QUESTIONNAIRE

We believe that each patient deserves to know what their current level of dental health is, how they got there, and what treatment options are available to help them reach the level of health that they deserve. This begins with a careful diagnosis and personalized treatment plan. We will perform a comprehensive oral examination of your teeth, gums, jaw joints, bite and soft tissues. We will also take the appropriate x-rays, and when beneficial we may take additional diagnostic records such as photographs or casts of your teeth to further evaluate areas of concern. Once all your records have been completed they will be carefully evaluated to determine your current level of dental health and how you got there. We will review our findings with you and discuss your treatment options. A personalized treatment plan will then be developed to help you achieve the goals we set together.

Please help us better understand your dental health needs and goals by answering the following questions. (check the best answer):

1. Have you had a full mouth set of x-rays (other than routine cavity detecting x-rays) within the last 3 years? [ ] **Yes** [ ] **No**
2. I have a [ ] **low** [ ] **moderate** [ ] **high** fear of going to the dentist.
3. My mouth and teeth are [ ] **very** [ ] **moderately** [ ] **not comfortable.**
4. I am [ ] **very satisfied** [ ] **satisfied** [ ] **dissatisfied** with the appearance of my teeth.
5. I think my present state of dental health is [ ] **excellent** [ ] **good** [ ] **fair** [ ] **poor.**
6. I would say that my main concerns with my dental health are:

____

7. I am interested in a smile evaluation and personalized treatment plan to enhance my smile. [ ] Yes [ ] No
8. Please check which statement below best represents the level of dental health you wish to achieve. *(Some people begin at one level and progress to a higher level over time.)*

[ ] **HEALTH LEVEL I - Emergency Care**
I am only interested in emergency dental care for the relief of pain and/or cosmetic embarrassment. I am not very interested in thinking about the future of my teeth at this time.
[ ] **HEALTH LEVEL II - Maintenance Care**
I am interested in maintenance care by taking an active part in the prevention of the disease process and the repair of existing problems. However, I am not yet ready for a higher level of dental care due to limitations of time and/or money. I understand that maintenance care may not be enough to help me achieve maximum protection and longevity and that my dental health may not remain stable over time.
[ ] **HEALTH LEVEL III - Comprehensive Care**
I am interested in comprehensive care to achieve and maintain a higher level of dental health. I am concerned about treating the causes of dental diseases, not simply the effects. I want all dental treatment provided to be the best available for maximum protection and longevity, so as to achieve long-term stable dental health.
[ ] **HEALTH LEVEL IV - Comprehensive & Cosmetic Care**
I am interested in comprehensive and cosmetic care to achieve and maintain the highest level of dental health. I am concerned about treating the causes of dental diseases, not simply the effects. I want all dental treatment provided to be the best available in cosmetic dentistry for maximum protection, longevity, and
esthetics, so as to achieve long-term stable, yet esthetic, dental health.