Health History

Physician's Name_____ Date of last visit_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fainting or dizziness	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No	Skin Rash	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Hepatitis Type_____	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Swelling of Feet or Ankles	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	HIV Positive	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Skin Cancer Family History	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Oral Cancer Family History	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Tumor or growth on head or neck	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No	Weight Loss, unexplained	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Women:		
Diabetes	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	Are you pregnant?	☐ Yes	☐ No
Relatives with Diabetes	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No	Due date_____		
Emphysema	☐ Yes	☐ No	Do you smoke?	☐ Yes	☐ No	Are you nursing	☐ Yes	☐ No
Do you wear contact lenses?	☐ Yes	☐ No	History of smoking	☐ Yes	☐ No	Ever had gestational diabetes?	☐ Yes	☐ No
			Exposed to second hand smoke	☐ Yes	☐ No			

List previous major surgeries and dates: _____

_____

Are there any other health problems of which you are aware? _____

_____

_____

Medications

List medications you are currently taking:

_____

_____

_____

Pharmacy Name_____

Phone_____

Allergies

☐ Aspirin ☐ Local Anesthetic

☐ Barbiturates (Sleeping pills) ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Iodine ☐ Other_____

☐ Latex ☐ No Allergies _____

Updates (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions?_____

Are you taking any new medications?_____ If so, what?_____

Patient's Signature_____ Date_____

Doctor's Signature_____ Date_____

Ideal Image

DENTISTRY & SPA
F.A. Landgrebe, D.D.S.
1008 East Main Street
Mandan ND 58554
(701) 667-1933

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please print (child/patient) name}

_____
{Signature (parent/guardian) name}

_____
{Date}

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

Name_____
Date _____

EXAMINATION QUESTIONNAIRE

Side 1

1. What prompted you to seek dental care at this time? _____
2. How long since your last dental examination? _____
3. Were x-rays of ALL teeth taken at that time? _____
4. How often do you have your teeth examined? _____
   Cleaned? _____ X-rayed? _____
5. Have you experienced any discomfort from your teeth or gums lately? _____
   If so, where? _____
6. Has the fear of discomfort kept you from regular dental visits? _____
7. When and how often do you brush your teeth? _____
8. Does food generally wedge between certain teeth? _____
   If so, where? _____
9. Are you troubled with bad breath? _____
10. Do your gums bleed easily, feel tender or irritated? _____
11. How often do you use dental floss? _____
12. Are your teeth sensitive to hot, cold, or sweets? _____
    If so, where and to what? _____
13. Do you frequently snack between meals, on starches, sweets, or chew gum? _____
    _____
14. Are you self-conscious about the appearance of your teeth? _____
15. Would you like to retain your healthy natural teeth as long as possible? _____
16. Are you aware of grinding or clenching your teeth? _____
17. Have you lost any teeth other than wisdom teeth? _____
    Have they been replaced? _____
18. Have you noticed any loose, shifted, or tipped teeth? _____
19. Have you had the nerves of any teeth removed? _____
20. Have you noticed any tooth darkening due to the nerve removal? _____
21. Have you noticed any tooth darkening due to black tarnishing of silver fillings? _____
    _____
22. Do you regularly have porcelain fillings replaced because of wash out or silver fillings because of breakage and chipping? _____
23. In the past, have you had the opportunity to choose your dental treatment? _____
    If so, what was your choice? Porcelain _____ Silver _____ Gold _____
24. Would you prefer a local anesthetic for most dental treatment? _____
25. Are you satisfied with your past dentistry? _____
26. How long since your last complete medical examination? _____
27. Are you interested in orthodontic treatment (braces), for you or a family member? _____
    _____
28. Are you under the care of a physician now? _____
    For what reason? _____

GET-ACQUAINTED QUESTIONNAIRE

In order for us to better serve you, please fill in the following information completely:

Date_____

Patient's Name: Mr. / Mrs. / Miss _____ Date of Birth _____ Age _____

Residence Address _____ City _____ How Long _____ Phone _____

Your Occupation _____ Employer _____ Phone _____

Employer's Address _____ City _____

Spouse's Occupation _____ Employer _____ Phone _____

Employer's Address _____ City _____

Person Financially Responsible _____ Relation to You _____

Social Security Number (Mr.) _____

(Mrs.)_____

Drivers License # _____

Former Dentist _____

Last Visit _____

Children – Names & Ages

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

Whom May We Thank for Referring You? _____

Reason for Appointment _____

FOR PATIENTS WITH DENTAL INSURANCE

Dental Insurance Carrier (Mr.) _____ (Mrs.)_____

Name of Union or Group Plan (Mr.)_____ (Mrs.)_____

Union Local Number (Mr.)_____ (Mrs.)_____

Group Number (Mr.)_____ (Mrs.)_____

If Patient is a Student – Name of School_____

Denti-Cal Number _____

Most dental insurance plans do not cover 100% of the cost of your treatment. Because of this and because of the extreme delay in receiving payment from insurance companies, you will be asked to pay a percentage of the charges before your treatment is completed.