

GET ACQUAINTED QUESTIONNAIRE

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

Date: _____

Patient's Name: _____ Date of Birth: _____ Age: _____

Home Address: _____ Sex: Male: _____ Female: _____

City: _____ State: _____ Zip: _____

Home Phone: () _____ Day sleeper in household? _____
Should we call your home during the day to leave appointment reminders? Yes _____ No _____

Cell Phone: () _____ Work Phone: () _____

Pager #: () _____ E-mail Address: _____

Your Occupation: _____ Employer: _____

Employer's Address: _____ City/State: _____ Zip: _____

Driver's License # /State _____ Dependent Children

Social Security # (Mr.) _____ 1. _____

(Mrs.) _____ 2. _____

Former Dentist: _____ 3. _____

Last Visit: _____ 4. _____

Spouse's Name: _____ Spouse's Occupation: _____ Employer: _____

Nearest relative/friend not living with you: _____ Phone: _____

Whom may we contact in the case of an emergency?

_____ Phone: _____

Whom may we thank for referring you to us? _____ Phone: _____

Reason for today's appointment: _____

Who is responsible for this bill? _____

I will be paying today by: cash _____ check _____ credit card _____

FOR PATIENTS WITH DENTAL INSURANCE

Dental Insurance Company _____ Group # _____

Subscriber Name _____ Subscriber's Date of Birth _____

Social Security # _____

Employer _____

Relationship to patient _____

If patient is a student, name of school: _____

(If student is over age 19 – verification of student status is required)

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 your estimated part of the charges before your treatment is completed.

Insurance claims will be sent in for you, and if we do not receive payment from them within 45 days then the account will become your responsibility. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on both sides of this sheet and have completed the answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my account, insurance or health information.

Signature: _____ Date: _____

Parent: (if minor) _____ Date: _____

I hereby authorize payment directly to Dr Robert G Marx D.D.S, the Group Insurance Benefits otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a timely manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to my insurance company.

I authorize Dr. Robert Marx to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Signature: _____ Date: _____

TELL US ABOUT YOUR MEDICAL HISTORY

First Name _____ Last Name _____

How would you describe your health? Please circle one Excellent Good Fair Poor

When did you have your last physical examination? _____

Are you currently being treated for any illness or medical condition? Yes _____ No _____

If yes, please describe: _____

Who is treating you for this condition? _____

Have you ever had any kind of surgery? Yes _____ No _____

What type of surgery did you have? _____

When did you have this surgery? _____

Have you ever had any trouble with prolonged bleeding after surgery? Yes _____ No _____

Do you wear a pacemaker or any other kind of prosthetic device? Yes _____ No _____

Are you taking or have you ever taken medications for osteoporosis? Yes _____ No _____

Are you taking any drugs or medications at this time? Yes _____ No _____

What medications or drugs or herbs are you taking? _____

Why are you taking these medications? _____

Have you ever had an unusual or allergic reaction to an anesthetic or drug (like Penicillin)? Yes _____ No _____

If yes, please explain _____

Please circle any present or past illness you now have or had in the past:

- | | | | | | |
|------------|-----------------|--------------------|---------------------|-----------------|------------------|
| Alcoholism | Blood Pressure | Epilepsy | Hepatitis | Kidney or Liver | Rheumatic Fever |
| Allergies | Cancer | Glaucoma | Herpes | Mental | Sinusitis |
| Anemia | Diabetes | Head/Neck Injuries | Immunodeficiency | Migraine | Ulcers |
| Asthma | Drug Dependency | Heart Disease | Infectious Diseases | Respiratory | Venereal Disease |

Are you allergic to Latex or any other substances or materials? Yes _____ No _____

If so please explain. _____

If female, are you pregnant? Yes _____ No _____

Is there any other information that should be known about your health? _____

Signature of Patient (or Parent) _____ Date _____

Periodontal Risk Assessment Questionnaire

Name _____ Date _____

Tobacco Use

Tobacco use is the most significant risk factor for gum disease.



Do you now or have you ever used the following:

	Amounts per day	Used for how many years	If you quit, list what year
<input type="checkbox"/> Cigarette	_____	_____	_____
<input type="checkbox"/> Cigar	_____	_____	_____
<input type="checkbox"/> Pipe	_____	_____	_____
<input type="checkbox"/> Chewing	_____	_____	_____

Blood Sugar



Diabetes

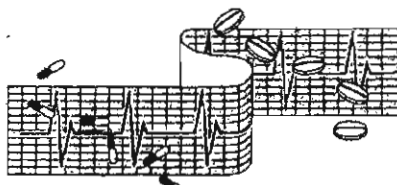
Gum disease is a common complication of diabetes. Untreated gum disease makes it harder for patients with diabetes to control their blood sugar.

IF YOU ARE A PATIENT WHO HAS DIABETES:

Is your diabetes under control? Yes No
 Are you prone to diabetic complications? Yes No
 How do you monitor your blood sugar? _____
 Who is your physician for diabetes? _____

IF YOU ARE NOT A PATIENT WHO HAS DIABETES:

Any family history of diabetes? Yes No
 Have you had any of these warning signs of diabetes?
 frequent urination excessive thirst
 excessive hunger weakness and fatigue
 slow healing of cuts unexplained weight loss



Heart Attack/Stroke

Untreated gum disease may increase your risk for heart attack or stroke.

Do you have any risk factors for heart disease or stroke?

Family history of heart disease Tobacco use Obesity
 High cholesterol High blood pressure

If you have any of these other risk factors it is especially important for you to always keep your gums as healthy as possible.

Medications

A side effect of some medications can cause changes in your gums.



Are you taking or have you ever taken any of the following medication:

Antiseizure medications. (such as Dilantin®, Tegretol®, Phenobarbital, etc.)
 Yes No
 If you answered yes, are you still taking the anti-seizure medication?
 Yes No

Other Medication: _____

Calcium Channel Blocker blood pressure medication. (such as Procardia®, Cardizem®, Norvasc®, Verapamil®, etc.)

Other: _____

Immunosuppressant therapy (such as Prednisone, Azathioprine, Cyclosporins, Corticosteroids (Asthma-Inhalers), etc.)

Other: _____

Family History/ Genetics

The tendency for gum disease to develop can be inherited.



Is there an immediate family member(s) who currently has or had gum problems in the past? (e.g. your mother, father, or siblings):

Yes No



Heart Murmur, Artificial joint prosthesis

If you have even the slightest amount of gum inflammation, bacteria from the mouth can enter the bloodstream and may cause a serious infection of the heart or joints.



Do you have a heart murmur or artificial joint?

- Yes No

If so, does your physician recommend antibiotics prior to dental visits?

- Yes No

Name of physician? _____

If you answered yes, it is especially important to always keep your gums as healthy and inflammation-free as possible to reduce the chance of bacterial infection originating from the mouth.



Females

Females can be at increased risk for gum disease at different points in their lives.

The following can adversely affect your gums. Please check all that apply:

- Pregnant Nursing Menopause
 Taking birth control pills
 Infrequent care during previous pregnancies

Women

Women with osteoporosis have a greater risk for periodontal bone loss.



Females:

Do you take any of the following:

- Estrogen Replacement Therapy/Hormone Replacement Therapy (such as Prempro®, Premarin®, Premphase®, Fosamax®, Actonel®, Evista®, Fortéo®, etc.)

Other: _____



Stress

High levels of stress can reduce your body's immune defense.

Are you under a lot of stress?

- Yes No

Nutrition

Your diet has the potential to affect your periodontal health.



Do you find it difficult to maintain a well-balanced diet?

- Yes No

All patients please complete the following:



Have you noticed any of the following signs of gum disease?

- Bleeding gums during toothbrushing Pus between the teeth and gums
 Red, swollen or tender gums Loose or separating teeth
 Gums that have pulled away from the teeth Change in the way your teeth fit together
 Persistent bad breath Food catching between teeth

Is it important to keep your teeth for as long as possible? Yes Not really

If you have missing teeth, why have you not had them replaced? _____

Do you like the appearance of your smile? Yes No

Do you like the color of your teeth? Yes No

Do your teeth keep you from eating any specific food? Yes No