
**ABOUT YOU**

Name: _____ ☐ Female ☐ Male

Mailing Address: _____City: _____

State: _____ Zip: _____Birth Date: _____/____/_____ Age_____

Home Phone: _____ Work Phone: _____

Cell Phone: _____Accept Texts? ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Widowed Social Security #:_____

Email Address: _____

How did you hear about our office? _____

**EMERGENCY INFORMATION**

Person to contact: _____Relationship_____

Phone Number_____

**DENTAL INSURANCE INFORMATION**

Insurance Company Name: _____

Group #:_____Member ID:_____

Employer: _____

If spouse is your policy holder:

Spouse's Name: _____

Spouse's Birth Date: _____/_____/_____ Spouse's SS #:_____

Spouse's Employer: _____

Secondary Coverage ☐ Yes ☐ No

**ASSIGNMENT & RELEASE**

I hereby authorize my insurance benefits be paid directly to the dentist, Dr. Eric R. Koch. I am financially responsible for any balances due and authorize the release of any information for this claim. I authorize that my records can be used by Dr. Koch if he so determines. In consideration of the services rendered to me by this dental office I am obligated to pay said office in accordance with its credit terms and policy. I consent the making of video tapes, photographs and x-rays before, during, and after treatment, and to the use of same by the doctor in scientific papers or demonstrations. I certify that I have read or had read to me the contents of this form and do realize the risk and limitations involved.

**SIGNATURE:_____**

**APPOINTMENT CANCELLATION POLICY**

When you schedule an appointment, we reserve that time and prepare in anticipation of serving you. If you need to reschedule, **we kindly request that you contact us by phone with advanced notice of two business days.** We understand that conflicts arise; however, failing to arrive for your appointment or canceling without adequate notice more than once will result in a $50 charge and then discontinuation of services. **INITIALS: _____ DATE: _____**

**PATIENT:** _____ **DATE:** _____

# DENTAL HISTORY

**Please check any of the following that apply to you:**

- ☐ Sensitivity (hot, cold, sweet)
  Where: UR LR UL LL
- ☐ Sore teeth
- ☐ Avoid brushing any part of your mouth
- ☐ Teeth or fillings breaking
- ☐ Lost any teeth
- ☐ Loose, tipped or shifting teeth
- ☐ Bad breath
- ☐ Unpleasant taste or odor in your mouth
- ☐ Burning sensation in mouth
- ☐ Mouth ulcers or cold sores
- ☐ Bleeding, swollen or irritated gums
- ☐ Difficulty swallowing
- ☐ Headaches, earaches, neck or jaw joint pain
- ☐ Grinding or clenching teeth
- ☐ Jaw clicking or popping
- ☐ Difficulty opening mouth widely
- ☐ Stiff neck muscles
- ☐ Unhappy with the appearance of your teeth
- ☐ Unfavorable dental experience
- ☐ Dental Fear
- ☐ Problems with effectiveness or reactions to dental anesthetic

**Please share the following dates (mm/yy):**

- Your last cleaning: ____/____
- Your last oral cancer screening: ____/____
- Your last complete x-ray's: ____/____

**Do you have or have you had any of the following:**

- ☐ Dentures
- ☐ Partial dentures
- ☐ Braces
- ☐ Gum treatments

**If I could change my smile, I would:**

- ☐ Make my teeth whiter
- ☐ Make my teeth straighter
- ☐ Close spaces
- ☐ Replace metal fillings with tooth colored restorations
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns that don't match
- ☐ Have a smile makeover

**On a scale of 1 – 10, 10 being the highest rating:**

---How important is your dental health to you?

**1 2 3 4 5 6 7 8 9 10**

---Where would you rate your current dental health?

**1 2 3 4 5 6 7 8 9 10**

**What is the most important thing to you about your future smile and dental health?**

_____

_____

**What is the most important thing to you about your dental visit today?** _____

_____

How often do you have your teeth cleaned? ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 1 yr. or longer

Are you interested in having regular cleanings? ☐ Yes ☐ No

Is saving your teeth important to you? ☐ Yes ☐ No

**Previous Dentist Information:**

Name: _____

City: _____ State: _____ Zip _____ Phone # _____

Reason for leaving your previous dentist? _____

_____

☐ *The information I have given is true and accurate to the best of my knowledge.*

_____ _____

**Signature** **Date**

**PATIENT:** _____ **DATE:** _____

## MEDICAL HISTORY

**Please check any of the following that apply to you:**

- ☐ AIDS/HIV Positive
- ☐ Allergies (seasonal)
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
  Date: _____
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problems
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Chronic Pain
- ☐ Depression
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Dizziness/Fainting
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy/Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fatigue
- ☐ Frequent Cough
- ☐ Frequent Diarrhea
- ☐ Headaches/Migraines
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Conditions
- ☐ Heart Murmur
- ☐ Heart Pace Maker
- ☐ Hepatitis Type _____
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Parathyroid Disease
- ☐ Phen Fen (1 month +)
- ☐ Psychiatric Care
- ☐ Radiation (head/neck)
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ OTHER (please list)

  _____
  _____
  _____

**For Women Only:**

- ☐ Birth Control Pills
- ☐ Breastfeeding
- ☐ Pregnant
  - ☐ **1-3 months**
  - ☐ **3-6 months**
  - ☐ **6-9 months**

**Please check if you are allergic to any of the following:**

☐ Local Anesthetics ☐ Sulfa Drugs ☐ Codeine ☐ Latex ☐ Penicillin ☐ Aspirin
☐ Fluoride ☐ Metals ☐ Other (please list) _____

_____

Do you smoke or use chewing tobacco? ☐ Yes ☐ No
Please list prescription medications/vitamins/herbal supplements that you currently take: _____

_____

_____

Are you under a physician's care? ☐ Yes ☐ No
Reason: _____

Family Physician _____ Phone_____

X_____ _____
**Signature - Patient/Responsible Party** **Date**