Welcome to the office of

Dr. Nanette Tertel, DDS

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. This questionnaire enables us to evaluate your general health and to assure that your dental treatment will be given safely and comfortably. Please fill out this form completely. The better we communicate, the better we can care for you. If you have any questions, please feel free to ask Toni, Jonelle, Sandy, or Jen!

About You ...

Name _____

Prefer to be called _____ ☐Male ☐Female

Birthdate _____ Age _____ SS# _____

Home Address _____

_____

City State Zip

☐Single ☐Married ☐Divorced ☐Widowed ☐Other

Home Ph# _____ Cell# _____

Work Ph# _____

Employer _____

Employer Address _____

Occupation _____

When & where are the best times to reach you?

_____

Who may we *thank* for referring you? _____

Previous/Present Dentist _____

Last Dental Visit Date _____

About Your Spouse ...

Spouse's Name _____

Employer _____

WorkPh# _____ SS# _____

Person responsible for account _____

WorkPh# _____ HomePh# _____

Billing Address _____

_____

City State Zip

Relationship _____

Employer _____

SS# _____

If you have dental insurance, please bring your card to the front desk and skip to the "Dental History" section.

About Your Dental Insurance ...

Primary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

_____

Insurance Co. Ph# _____

Group/Plan/Policy # _____

Insured's Name _____

Relation _____ Insured's SS# _____

Insured's Birthdate _____ Employer _____

Secondary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

_____

Insurance Co. Ph# _____

Group/Plan/Policy # _____

Insured's Name _____

Relation _____ Insured's SS# _____

Insured's Birthdate _____ Employer _____

Your Dental History ...

Why have you come to the dentist today? _____

_____

_____

Are you currently in **pain**? ☐Yes ☐No

☐Jaw pain ☐Gum pain ☐Pain on biting ☐Cold/hot

Have you ever had serious problem associated with previous dental work? ☐Yes ☐No

Do you now or have ever experienced pain or discomfort **in your jaw joint (TMJ)**? ☐Yes ☐No

Do you have ☐Joint clicking ☐Limited jaw movement

Have you ever had **periodontal surgery**? ☐Yes ☐No

Do you wear removable dental appliances? ☐Yes ☐No

Your current dental health is: ☐good ☐fair ☐poor

Do you like your **smile**? ☐Yes ☐No

Do your gums ever **bleed**? ☐Yes ☐No

How many times a day do you **brush**? _____

How many times a week do you **floss**? _____

Type of bristles? ☐Hard ☐Medium ☐Soft

Your Medical History ...

Your current health condition is: ☐Good ☐Fair ☐Poor

General Physician: _____ **City/State** _____
Are you currently under the condition of a physician or medical therapist? ☐Yes ☐No
If yes, please explain: _____
_____

Are you taking any prescription/over the counter drugs, herbs or vitamins? ☐Yes ☐No
If yes, please list names and dosages: _____
_____
_____

Are you allergic to any of the following?

☐ Penicillin	☐ Aspirin	☐ Erythromycin
☐ Tetracycline	☐ Epinephrine	☐ Dental anesthetics
☐ Codeine	☐ Demerol	☐ Latex
☐ Sulfa	☐ Other: _____	

Please list any other or possible known **allergies**: _____
Have you taken any **steroid medications** in the past twelve months? ☐Yes ☐No
Are you wearing contact lenses? ☐Yes ☐No

Have you ever had/have any of the following diseases or medical conditions?

☐ Heart Attack	☐ Stroke	☐ Cancer/Chemotherapy	☐ Hepatitis
☐ Heart Murmur	☐ Migraines	☐ Radiation Therapy	☐ HIV+/AIDS/ARC
☐ Mitral Valve Prolapse	☐ Frequent Headaches	☐ Digestive Ulcers	☐ Venereal Disease
☐ Rheumatic Fever	☐ Fainting Spells	☐ Colitis/Colostomy	☐ Shingles
☐ Angina	☐ Epilepsy/Seizures	☐ Diabetes	☐ Fever Blisters
☐ Heart Surgery	☐ Glaucoma	☐ Thyroid Problems	☐ Cold Sores
☐ Pacemaker	☐ Sinus Problems	☐ Difficulty Breathing	☐ Tuberculosis(TB)
☐ Congenital Heart Defect	☐ Kidney Problems	☐ Emphysema	☐ Arthritis
☐ High Blood Pressure	☐ Dialysis Shunt	☐ Asthma	☐ Hip/Knee Replacement
☐ Low Blood Pressure	☐ Abnormal bleeding	☐ Psychiatric Concerns	☐ Blood Transfusion
☐ Hemophilia	☐ Anemia	☐ Drug/Alcohol Abuse	☐ Prosthetic Implants

☐ Other: _____
_____
_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform with my informed consent, any necessary dental services I may need during diagnosis and treatment.

Signature _____ **Date** _____

Payment is due in full at the time of treatment unless prior arrangements have been made.

Thank you for filling out this form completely. It will enable us to help you more effectively.
If you have any questions at any time, please ask us. We are happy to help.

Date: _____ Date: _____ Date: _____
Signature: _____ Signature: _____ Signature: _____

Date: _____ Date: _____ Date: _____
Signature: _____ Signature: _____ Signature: _____