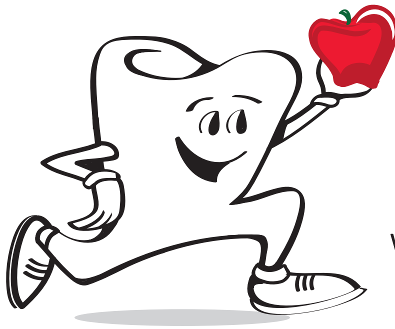

CASA GRANDE FAMILY DENTISTRY

"We cater to cowards"

NEW PATIENT INFORMATION

Welcome to Casa Grande Family Dentistry! So that we can better serve you, please take a moment to answer the following questions.

About You

❍ Mr. ❍ Mrs. ❍ Ms. ❍ Dr. First Name: ______________________ Last Name: ______________________

Date of Birth: ______________ Social Security #: ______________ ❍ Single ❍ Married ❍ Divorced ❍ Separated

Address: ______________________________ City: ________________ State: _______ Zip: ___________

Home Phone: ________________ Work Phone: ________________ Mobile Phone: ______________

Email: ______________________ Occupation: ________________ Employer: ________________

How did you hear about us? ____

Other family members seen by us? ____

Who may we thank for referring you? ____

Name of Spouse / Partner: ________________________ Names of Children: ____________________

____

# of Pets: _________ Personal interests: ____

Athletic interests: ____________________________ Favorite Music: ____________________________

Favorite Food: ________________________ Favorite Movie(s): _________________________________

Primary Dental Insurance

Name of Insurance: _______________________ Group # (plan, local, or policy #): ______________________

Insurance Address: ___________________________ City: _______________ State: _____ Zip: _________

Insurance Phone: ________________ First Name (of insured): ______________ Last Name: ______________

Birth date (of insured): _______________________ Social Security # (of insured): ______________________

Insured's Employer: ____

Policy Holder Information

Name (of policy holder): ______________________________ Relation (to insured): ____________________

Home Phone: ________________ Work Phone: ________________ Mobile Phone: ______________

Address: ______________________________ City: ________________ State: _______ Zip: ___________

Email: ____

Your Smile Information

How can we help you today? ____

Are you in any pain/discomfort? ________________ Who was your previous dentist? ____________________

Why did you leave your previous dentist? ____

When was your last cleaning? ___________ Oral Cancer screeening? ___________ Complete X-rays? ___________

Have you ever had any serious/difficult problem associated with any previous dental work? ❍ Yes ❍ No

If yes, please explain: ____

Do you or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ❍ Yes ❍ No

Has your doctor told you that you require antibiotics before dental treatment? ❍ Yes ❍ No

How many times a day do you brush? ________________ How many times a week do you floss? ________________

Type of toothbrush (if known): ______________________________
What are the most important things to you about your smile and dental heath? ______________________________
What do you like about your smile? ______________________________
What don't you like about your smile? ______________________________

Please check any problems that apply to you:

- ❍ Sensitivity
- ❍ Uncomfortable bite when chewing
- ❍ Grinding teeth
- ❍ Bad breath
- ❍ Teeth or fillings breaking
- ❍ Headaches, earaches, or neck pain
- ❍ Bleeding, swollen, or irritated gums
- ❍ Loose or shifted teeth
- ❍ Other: ______________________________

If you could change your smile, would you:

- ❍ Make your teeth whiter
- ❍ Make your teeth straighter
- ❍ Close spaces between your teeth
- ❍ Replace old crowns that don't match
- ❍ Replace missing teeth
- ❍ Repair chipped teeth
- ❍ Replace dark fillings with natural tooth-colored fillings
- ❍ Have a smile makeover
- ❍ Other: ______________________________

Your Physician Information

First Name: ____________________ Last Name: ____________________ Phone Number: ____________________
When was your last visit? _______________ How would you rate your current health? ❍ Excellent ❍ Fair ❍ Poor
Are you currently being treated for any condition? ❍ Yes ❍ No If yes, please explain why: ______________________

For Women

Are you taking birth control? ❍ Yes ❍ No Are you currently nursing? ❍ Yes ❍ No
Are you pregnant? ❍ Yes ❍ No If yes, when are you due? ______________________________

Your Health

Mark below if you have had any of the following diseases, conditions, or treatments:

- ❍ Abnormal Bleeding
- ❍ Alcohol/Drug Abuse
- ❍ Anemia
- ❍ Arthritis
- ❍ Artificial Bones, Joints, or Valves
- ❍ Asthma
- ❍ Blood transfusion
- ❍ Cancer/Chemotherapy
- ❍ Colitis
- ❍ Congenital Heart Defect
- ❍ Diabetes
- ❍ Difficulty Breathing
- ❍ Emphysema
- ❍ Epilepsy
- ❍ Fainting Spells
- ❍ Frequent Headaches
- ❍ Glaucoma
- ❍ Hay Fever
- ❍ Heart Attack
- ❍ Heart Murmur
- ❍ Heart Surgery
- ❍ Hemophilia
- ❍ Hepatitis
- ❍ Herpes/Fever Blisters
- ❍ High Blood Pressure
- ❍ HIV/AIDS
- ❍ Kidney Problems
- ❍ Liver Disease
- ❍ Low Blood Pressure
- ❍ Lupus
- ❍ Osteoporosis
- ❍ Mitral Valve Prolapse
- ❍ Nervous Disorders
- ❍ Pacemaker
- ❍ Psychiatric Care
- ❍ Radiation Treatment
- ❍ Respiratory Problems
- ❍ Rheumatic Fever
- ❍ Seizures
- ❍ Shingles
- ❍ Sickle Cell Disease
- ❍ Sinus Problems
- ❍ Stroke
- ❍ Thyroid Problems
- ❍ Tuberculosis (TB)
- ❍ Ulcers
- ❍ Venereal Disease
- ❍ Smoking or Tobacco Use

Please list any medical condition not mentioned above: ______________________________
Have you ever been hospitalized? ❍ Yes ❍ No If yes, please explain why: ______________________________
Are you taking any prescribed, over-the-counter, or herbal supplement drugs? ❍ Yes ❍ No
If yes, please list: ______________________________
Do you have any allergies? ❍ Yes ❍ No If yes, please list: ______________________________

Have you ever had an adverse reaction to any of the following? ❍ Aspirin ❍ Latex ❍ Codeine ❍ Penicillin
❍ Anesthetics ❍ Antibiotics ❍ Ibuprofen ❍ Erythromycin ❍ Tetracycline ❍ Jewelry/Metals
Please list any other medications or issues we should be made aware of: ____

____

Emergency Contact Information

In the even of an emergency, who should we contact?
First name: __________________________ Last name: ___________________________ Relation: __________________________
Home Phone: ________________________ Work Phone: _________________________ Mobile Phone: ____________________

Patient Acknowledgements

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

In the event that payment in full for charges incurred is not made, I agree to pay off all costs of collection including all collection fees, attorney fees, and court costs.

Signature: ____
Printed name: ____ Date: ______________________________

Privacy Practices*

Daryl B. Potyczka, D.D.S., Acknowledgement of Notice of Privacy Practices
**You may refuse to sign this acknowledgement.*

I,____, understand that Dr. Potyczka's office abides by the HIPAA Law and will protect the privacy of my personal information.

Signature: ____
Printed name: ____ Date: ______________________________

For Office Use Only

We attempted to obtain written acknowledgement for the receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

❍ Individual refused to sign.
❍ Communication barriers prohibited us from obtaining acknowledgement.
❍ An emergency situation prevented us from obtaining acknowledgement.
❍ Other (Please specify): ____