

Welcome



We are happy to have you join our great family of patients and friends. The benefits of a healthy, beautiful smile are immeasurable, and our goal is to help you to obtain the healthy teeth and attractive smile you want and deserve. Please complete this form so we can provide the best care possible for you. Thank you!

About You

Name (first, MI, last) _____

How would you like to be addressed? _____

How did you hear about Dr. Flax? _____

Address _____

City / State / Zip _____

Day Phone _____

Evening Phone _____

Mobile _____

Email _____

Birth date _____

Male Female Married Single Divorced Widowed

Social Security No. _____

Emergency Contact Name/No. _____

About You

Occupation _____

Employer _____

Address _____

Phone _____

Your spouse

Name _____

Occupation _____

Employer _____

Address _____

Phone _____

Insurance

Primary Insurance Company _____

Insurance Phone No. _____

Group No. _____

Employer _____

Insured's Name _____

Insured's ID No. _____

Insured Social Security No. _____

Insured's Birth Date _____

Relationship to Patient _____

Your Health



Name _____

Have you been under the care of a medical doctor during the past two years? Y N

If Yes, what for? _____

Physician's name _____ Phone _____

Location/Address _____

Have you taken any medications or drugs during the past two years? Y N

if yes, please list any medication or drugs you have taken during the past two years.

Are you taking any medication or drugs currently, including regular doses of aspirin, over-the-counter meds or herbal meds? Y N

If yes, please list name and dosage _____

Are you aware of having any allergic or adverse reactions to any medication or substance? Y N

If yes, please list _____

Have you been a patient in the hospital during the past five years? Y N

Have you lost or gained more than 10 pounds in the past year? Y N

Do you take a bone-building drug such as Fosamax, Actonel, Zometa, or Pamidronate? Y N

If so, orally or IV? (circle one)

Do you currently use tobacco? Y N

If so, how long? _____ Do you want to quit? Y N

Indicate which of the following you have had or have at present:

- | | | | |
|--|-----|---|-----|
| Heart (Surgery, Disease, Attack). | Y N | Emphysema. | Y N |
| Congenital Heart Disease | Y N | Tuberculosis. | Y N |
| High Blood Pressure | Y N | Asthma | Y N |
| Artificial Heart Valve | Y N | Latex Sensitivity | Y N |
| Heart Pacemaker. | Y N | Allergies/Sinus Trouble | Y N |
| Arthritis/ Rheumatism | Y N | Radiation/Chemotherapy | Y N |
| Cortisone Medicine. | Y N | Tumors. | Y N |
| Swollen Ankles | Y N | Hepatitis A B C. | Y N |
| Stroke | Y N | Venereal Disease / AIDS / HIV | Y N |
| Diet (Special/Restricted). | Y N | Cold Sores/Fever Blisters | Y N |
| Artificial Joints (hip, knee, etc) | Y N | Blood Transfusion | Y N |
| Kidney Trouble | Y N | Bruise Easily | Y N |
| Diabetes | Y N | Liver Disease / Yellow Jaundice | Y N |
| Thyroid Problems | Y N | Neurological Disorders | Y N |
| Glaucoma | Y N | Epilepsy or Seizures | Y N |

Do you have or have you had any disease, condition, or problem not listed? Y N

If yes, please list _____

Your Health continued



SLEEP HABITS

- Do you use more than two pillows to sleep? Y N
- Do you have any trouble sleeping? Y N
- Do you snore, or have you been told that you do? Y N
- Do you awaken with jaw or head pain? Y N

WOMEN

- Are you pregnant or think you may be pregnant? Y N
- Are you nursing? Y N
- Do you use birth control medication? Y N

Type: _____

Are you:

- Considered a touchy person Y N
- Often unhappy or depressed Y N
- Easily upset or irritated Y N
- Often exhausted or fatigued Y N

I understand that to the best of my knowledge, the questions on this form have been accurately answered. I have documented my medical history and confirm it states past and present conditions. I understand it will be held in the strictest of confidence and it is my responsibility to inform this office of any medical status or condition. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I authorize Flax Dental to perform all necessary dental procedures that I may need with my informed consent. I also give permission to Flax Dental to use any photos that may be taken used for lecturing, publishing, marketing, and educational purposes.

Patient/Guardian Signature _____ Date _____

Dr. Hugh Flax's Review

Doctor's Signature _____ Date _____

Your Health



Name _____

TELL US ABOUT YOU! *The better we understand you, the better we can serve you.*

Please make a mark along each scale below to indicate your opinion or preference.

I know a great deal about my dental condition		I know very little about my dental condition
I like to be presented with fewer options		I like to be presented with more options
I tend to look at the details		I tend to look at the big picture
I prefer long lasting solutions which may initially cost more		I prefer temporary solutions at lower cost
I prefer to talk in technical terms with my dentist		I prefer to talk in non-technical terms
My insurance largely determines the extent of my care		I largely determine the extent of my care
I prefer to wait until I must act		I usually see no reason to delay care
I rely more on self-maintenance		I rely on more professional maintenance
I like newer and more modern techniques		I like tried and true methods

In order of importance, I generally consider the following benefits (Please rank 1 through 7 or 8):

_____ Comfort _____ Function _____ Health _____ Appearance
_____ Precision _____ Peace of Mind _____ Durability _____ Other

In order of importance, I generally weigh the following in making a decision regarding my dental health (Please rank 1 through 5 or 6):

_____ Money _____ Time _____ Personal Effort
_____ Physical Discomfort _____ Fear/Anxiety _____ Other

Dental History



Name _____

Have you been under the care of a medical doctor during the past two years? Y N

If Yes, what for? _____

What prompted you to call our office for an appointment? _____

When was the last time you were seen by a dentist? _____

Did you have regular dental care as a child? Y N

As a child, did you have a lot, average, or very little tooth decay? _____

Do you have any dental anxieties? _____

If so, what is the origin of your anxiety? _____

Have you had or do you prefer Nitrous Oxide (laughing gas) during dental procedures? _____

Has a dental office ever helped you set up a treatment plan? _____

As you come into Flax Dental, what are your expectations, concerns, and or/priorities? _____

If you could wave a magic wand and change anything about the appearance of your smile, what would you like to do? _____

Guided Tour Through Your Mouth ~

Would you like your teeth straightened? Y N

Are you interested in Sedation Dentistry? Y N

Do you want your teeth whitened? Y N

Have you had cosmetic dentistry (eg. Bonding, Veneers)? _____

Periodontal Screening ~

Have you ever had a bone loss evaluation? Y N

Have you ever had pocket measurements? Y N

Have you ever had Root Planing? Y N

Do you know your plaque score? Y N

Do you suspect that you have mouth odor? Y N

Have you ever been treated for periodontal disease? Y N

Have you noticed any loosening or mobility of your teeth? Y N

Do you suffer from pain and/or swelling of your gums, or have any pus around your gums? Y N

Dental History continued



Problems of the Jaw ~

- Have you ever been treated for TMJ? Y N
- Do you have more than one bite or have to clench to make your teeth fit together? Y N
- Do you wear or have you worn a bite appliance? Y N
- Are you teeth crowding or developing spaces? Y N
- Have you ever experienced:
 - Clicking of the joints? Y N
 - Pain? Y N
 - Difficulty chewing? Y N
 - Chewing what? _____
 - Locking? Y N
 - Chronic neck or shoulder pain? Y N
 - Chronic headaches? Y N
 - Morning headache? Y N
 - Migraine headache? Y N

Habits ~ Do you...

- Clench your teeth during the day? Y N
- Grind your teeth at night? Y N
- Bite your lips or cheeks regularly? Y N
- Sleep with your mouth open? Y N
- Chew tobacco or snuff? Y N
- Smoke cigarettes? Y N
- Hold foreign objects with your teeth (pencils, etc.)? Y N
- Have your teeth changed in the last five years? Y N

Become Shorter, Worn, or Thinner (circle one)

Please share with us any additions thoughts, comments, or concerns regarding your dental experiences or expectations ~

Name _____ Date _____

Sleep & Snoring



Quality of sleep is very much related with oral health and overall wellness.

Please answer these few questions regarding your sleep patterns.

How likely are you to fall asleep in certain situations?

Please circle the answer that applies best to you

SITUATIONS	CHANCE OF FALLING ASLEEP			
	<i>Would Never</i>	<i>Slight</i>	<i>Moderate</i>	<i>High Chance</i>
a.) Sitting and Reading	0	1	2	3
b.) Watching TV	0	1	2	3
c.) Sitting inactive in a public place (theater or meeting)	0	1	2	3
d.) Riding as a passenger in a car for more than 1 hour	0	1	2	3
e.) Lying down to rest in the afternoon when time permits	0	1	2	3
f.) Sitting and talking to someone	0	1	2	3
g.) Sitting quietly after lunch (without alcohol)	0	1	2	3
h.) In a car, while stopped for a few minutes in traffic	0	1	2	3

Your Consent



I hereby authorize Dr. Hugh Flax and his team to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by Dr. Flax to make a thorough diagnosis of _____ dental needs.

Upon such diagnosis, I authorize Dr. Flax to perform all recommended treatment mutually agreed upon by me and to employ assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I give consent to Dr. Flax and his team use and disclosure of any oral, written, or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is also available.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. If insurance is filed for me, I agree to pay what insurance does not cover within 30 days.

_____ Date _____

Your Signature

Witness

Responsible Party's Signature

Relationship to Patient