Gentle Family Dentistry and Orthodontics
CHARLES C. CLAUSEN, D.D.S., P.C.

The benefits of a happy, healthy smile are immeasurable!
Our goal is to help you reach and maintain maximum oral health.
Please fill out this form completely, so we may serve you better.

1 ABOUT YOU

Today's Date ____________________

Name: ______________________________________
LAST FIRST MI MR MRS MS DR.

I prefer to be called: ____________________ ☐ Male ☐ Female

If child, parents name: ______________________________

Birthdate: __________ Age: ____ SS #: ________________

Home address: ______________________________

City/State/Zip: ______________________________

Email address: ______________________________

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Seperated

Home #: ______________________________

Wk #: ______________________ Ext: __________

Cell #: ______________________________

Employer: ______________________________

Employer's address: ______________________________

City/State/Zip: ______________________________

Occupation: ______________________________

How long there? ______________________________

Where & when are best times to reach you? ________________

Who may we Thank for referring you? ________________

Purpose of this appointment? ________________

2 SPOUSE INFORMATION

Spouse Name: ____________________ Birthdate: ________

Employer: ____________________ Occupation: ________

Address: ______________________________

City/State/Zip: ______________________________

Wk #: ______________ Ext: ___ SS #: ____________

Cell #: ______________________________

Person Responsible for Account: ____________________

☐ If patient is responsible party, please check this box and go on to Section 3.

Wk #: ____________ Ext: ______ Hm #: ____________

Billing Address: ______________________________

City/State/Zip: ______________________________

Relationship: ______________ SS #: ______________

Employer: ____________________ Birthdate: ________

3 DENTAL INSURANCE

Primary Dental Insurance

Insurance Co. Name: ______________________________

Insurance Co. Phone #: ______________________________

Insured's Name: ____________________ Relation: ________

Insured's Birthdate: ________ Insured's SS #: ______________

Insured's Employer: ______________________________
IF RETIRED, USE LAST EMPLOYER

Address: ______________________________

City/State/Zip ______________________________

Secondary Dental Insurance

Insurance Co. Name: ______________________________

Insurance Co. Phone #: ______________________________

Insured's Name: ____________________ Relation: ________

Insured's Birthdate: ________ Insured's SS #: ______________

Insured's Employer: ______________________________
IF RETIRED, USE LAST EMPLOYER

Address: ______________________________

City/State/Zip ______________________________

I authorize the release of information necessary for the processing of insurance claims and assign benefits to Dr. Charles C. Clausen, D.D.S., P.C.

Signature: ______________________________

In case of emergency, whom should be notified? ________________

____

____

Phone #: ______________________________

4 FINANCIAL RESPONSIBILITY

I acknowledge that I am responsible for all charges for services provided, including any amount not paid by my insurance plan. If collection procedures become necessary I agree to pay all attorney and collection fees.

I acknowledge I have received a copy of this office's Notice of Privacy Practices.

I also authorize the release of all dental information necessary for processing insurance claims to my insurers or any third party or their agents.

I understand that 48 business hours notice for cancellations is required or I may be subject to a $75 service fee.

____
PATIENT/INSURED SIGNATURE DATE

5 MEDICAL / DENTAL HISTORY

Physician's Name: ____________________

Phone #: ____________ Date of last visit: ________

Height: ______ Weight: ______ Blood Pressure: ________

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

Are you currently under the care of a physician? ☐ No ☐ Yes

Please explain: ____________________

Are you taking any medications? ☐ No ☐ Yes

Are you taking any herbal supplements? ☐ No ☐ Yes

Please list each one: ____________________

When was your last dental appointment? ____________

When was your last full mouth X-Ray taken? ____________

Where? ____________________

For Women: Are you taking any birth control pills? ☐ No ☐ Yes

Are you pregnant? ☐ No ☐ Yes Week #: ________

Are you nursing? ☐ No ☐ Yes

Do you have or have you ever had:

- Blood Transfusion .... ☐ No ☐ Yes
- Severe/Frequent headaches .... ☐ No ☐ Yes
- Pain in or near your ears .... ☐ No ☐ Yes
- Growth or sore spots in your mouth .... ☐ No ☐ Yes
- Mouth hurts when clenched .... ☐ No ☐ Yes
- Gums bleed .... ☐ No ☐ Yes
- Do you at the present time have any dental complaints .. ☐ No ☐ Yes
- Do you habitually clench your teeth during the night or day. ☐ No ☐ Yes
- Any part of your mouth sore to pressures or irritants (cold, sweets, etc.) .... ☐ No ☐ Yes
- Do you use tobacco products .... ☐ No ☐ Yes

Are you allergic to:

- Penicillin .... ☐ No ☐ Yes
- Local anesthetic .... ☐ No ☐ Yes

Other medications or drugs: ____________________

Have you been hospitalized in the last 5 years? .... ☐ No ☐ Yes

If so, for what ____________________

6 MEDICAL / DENTAL HISTORY Cont.

- Do you take aspirin? .... ☐ No ☐ Yes
- Do you take blood thinners? .... ☐ No ☐ Yes
- Do you take bisphosphonates? .... ☐ No ☐ Yes

Do you have or have you ever had:

- HIV Positive .... ☐ No ☐ Yes
- Anemia .... ☐ No ☐ Yes
- Asthma .... ☐ No ☐ Yes
- Diabetes .... ☐ No ☐ Yes
- Epilepsy .... ☐ No ☐ Yes
- Hepatitis .... ☐ No ☐ Yes
- Rheumatic Fever .... ☐ No ☐ Yes
- Artificial Joints .... ☐ No ☐ Yes
- Heart Murmur .... ☐ No ☐ Yes
- Mitral Valve Prolapse .... ☐ No ☐ Yes
- Abnormal Heart Condition .... ☐ No ☐ Yes
- Abnormal Bleeding From A Cut .... ☐ No ☐ Yes
- Abnormal Blood Pressure .... ☐ No ☐ Yes
- Respiratory Disease .... ☐ No ☐ Yes
- Pulmanory Shunts .... ☐ No ☐ Yes
- Rheumatism or Arthritis .... ☐ No ☐ Yes
- Tumors or Growths .... ☐ No ☐ Yes
- Any Blood Disease .... ☐ No ☐ Yes
- Any Liver Disease .... ☐ No ☐ Yes
- Any Kidney Disease .... ☐ No ☐ Yes
- Any Stomach or Intestinal Disease .... ☐ No ☐ Yes
- Any Venereal Disease .... ☐ No ☐ Yes

7 APPEARANCE SATISFACTION

Are you satisfied with the appearance of your teeth? ☐ No ☐ Yes

If NO, what concerns do you have about the appearance of your teeth?

____

What changes, if any, would you like to make to your smile? ________

____