Holly M. Austgen D.D.S.

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient Information (CONFIDENTIAL)

Date _____

Name _____ Birthdate _____ SS# _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Patient or Parent/Guardian's Employer _____ Work Tel. _____

Address of Employer _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Tel. _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Tel. _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Tel. _____

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No Work Tel. _____

For your convenience, we offer the following methods of payment. Please check the option you prefer. Your estimated portion of payment is expected at each appointment.

☐ Cash ☐ Personal Check ☐ VISA ☐ MasterCard Credit Card ☐ I wish to discuss office financing

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS# _____ Home Tel. _____

Name of Employer _____ Union/Local# _____ Work Tel. _____

Insurance Company _____ Group# _____ Ins. Tel. _____

Ins. Co. Address _____ City _____ State _____ Zip _____

DO YOU HAVE ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS# _____ Home Tel. _____

Name of Employer _____ Union/Local# _____ Work Tel. _____

Insurance Company _____ Group# _____ Ins. Tel. _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Over Please

Patient Medical History

Physician _____ Office Tel. _____ Date of Last Exam _____

Are you under a physician's care now? ☐ Yes ☐ No If yes, explain _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, explain _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No

Are you taking medication, pills, or drugs? ☐ Yes ☐ No If yes, please list _____

Have you ever taken any of the following medications?

☐ Fosamax ☐ Aredia ☐ Boniva ☐ Zometa ☐ Didronel ☐ Skelid ☐ Actonel

Do you use tobacco? ☐ Yes ☐ No Do you use controlled substances? ☐ Yes ☐ No

Women: Are you ☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other _____

Do you have or have you had any of the following?

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequently Tired	☐ Hypoglycemia	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Excessive Thirst	☐ Irregular Heartbeat	☐ Sinus Trouble
☐ Anemia	☐ Congenital Heart Disorder	☐ Frequent Headaches	☐ Kidney Problems	☐ Stomach Disease/Trouble
☐ Angina	☐ Cortisone Medicine	☐ Glaucoma	☐ Leukemia	☐ Stroke
☐ Arthritis/Gout	☐ Diabetes	☐ Hay Fever	☐ Liver Disease	☐ Swelling of Limbs
☐ Artificial Heart Valve*	☐ Easily Winded	☐ Heart Disease/Trouble*	☐ Low Blood Pressure	☐ Thyroid Disease
☐ Artificial Joint*	☐ Emphysema	☐ Heart Murmur	☐ Mitral Valve Prolapse*	☐ Tuberculosis
☐ Asthma	☐ Epilepsy or Seizures	☐ Heart Pacemaker*	☐ Radiation Treatments	☐ Tumors/Growths
☐ Bruise Easily	☐ Excessive Bleeding	☐ Hemophilia	☐ Recent Weight Loss	☐ Ulcers
☐ Cancer	☐ Fainting Spells	☐ Hepatitis A, B or C	☐ Rheumatic Fever*	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Cough	☐ High Blood Pressure	☐ Rheumatism	☐ Other

Have you ever had any illness not listed above? ☐ Yes ☐ No If yes, please explain _____

Comments: _____

Patient Dental History

Name of previous Dentist and Location _____ Date of last exam _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot, cold or sweets?	☐	☐
3. Do you feel pain to any of your teeth?	☐	☐
4. Do you like the color of your teeth?	☐	☐
5. Do you like your smile?	☐	☐
6. Do you have spaces or missing teeth that you don't like? If yes, explain _____	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening, closing or chewing	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Have you ever had any prolonged bleeding following extractions?	☐	☐
11. Have you had orthodontic treatment?	☐	☐
12. Do you wear dentures or partials? If yes, date of placement _____	☐	☐
13. Have you ever received oral hygience instructions regarding the care of your teeth and gums?	☐	☐

14. Is there anything about your smile you wish you could change? If yes, how would you like your teeth to look? _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____ Date _____

Signature of patient (or parent/guardian if minor)