

Welcome

DENTAL INSURANCE INFORMATION

(The information below is for the subscriber of the insurance)

Name of Insured: _____

Birthday: _____ SSN: _____

Relation: _____

Insurance Company: _____

Insurance Address: _____

_____ City State Zip

Group #: _____

Phone #: _____

Insured Employer: _____

ABOUT YOU

Today' Date: _____

Please Circle one: Dr. Mr. Mrs. Ms. Miss

Patient Name: _____
Last First MI

Preferred Name: _____ M [F

Birthday: _____ SSN: _____

Married **P** Single Divorced Widowed Minor

Address: _____

_____ City State Zip

Drivers License # _____ Exp _____

Home Phone: _____

Cell Phone: _____

Email: _____

Work Phone: _____

Employer: _____

We now have the ability to confirm your appointments via text message and/or email.

Would you like text and/or email reminders?

Text Y N Email Y N

Whom may we thank for referring you to our practice? or How did you hear about us? _____

Have you seen our ad in New Beauty magazine? Y N

EMERGENCY CONTACT

Whom should we contact? _____

Relation: _____

Home Phone #: _____

Work Phone #: _____

Cell Phone #: _____

Who is your Medical Doctor? _____

Medical Doctor's Phone# _____

RESPONSIBLE PARTY

Name: _____

Relation: _____

Billing Address (If different): _____

_____ City State Zip

SSN: _____ Birth Date: _____

Work #: _____ Ext: _____

Cell #: _____ Drivers Lic. # _____

PLEASE CONTINUE ON BACK

PATIENT INFORMATION

DENTAL INFORMATION

Are you in pain? Y N How Long? _____

Are your teeth sensitive to? Hot Cold Sweets Pressure

Do your gums hurt or bleed? Y N When? _____

How often do you brush and floss your teeth? _____

Have you ever had any Orthodontic treatment? Y N When? _____

Reason for Today's visit? _____

MEDICAL INFORMATION

Do you have any of the following diseases, medical conditions or procedures? Please check all that applies.

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Heart Attack/Stroke | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Cancer/tumors | <input type="checkbox"/> Cosmetic Surgery |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> HIV | <input type="checkbox"/> AIDS/ARC | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Artificial Valve | <input type="checkbox"/> Stomach Problems/Ulcers | <input type="checkbox"/> Artificial Bones/Joints | <input type="checkbox"/> Diabetes/Hypoglycemia |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Psychiatric Problem | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Fainting | <input type="checkbox"/> Seizure |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Anemia | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Alcohol/Drug Abuse |
| <input type="checkbox"/> Severe/Frequent Headache | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Tuberculosis TB |
| <input type="checkbox"/> Frequent Neck Pain | <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Jaw Problem TMJ/TMD |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pregnancy | |

Are you allergic to any medications? Y N
Please List: _____

Are you taking any herbs or natural supplements? Y N
Please List: _____

Are you taking any medications? Y N
Please List: _____

Do you have any health problems that are not listed or need further clarification? Y N
If yes, please explain: _____

Do you smoke? Y N
If so, how much? _____

Are you taking any blood thinners? (i.e.: Aspirin) Y N
Please List: _____

- ❖ We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.
- ❖ Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the care coordinator. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, interest charges and any other expenses incurred in collecting your account.
- ❖ I understand that the fee estimate listed for this dental care can only be extended for a period of six month from the date of the patient examination.
- ❖ I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- ❖ I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature (Patient, Parent or guardian)

Date

**Notice of Privacy Practices
for Gregg C. Hendrickson DDS & Associates LLP and Synergy Spa LLC**

This notice describes how information about you may be used and disclosed and how to get access to this information. Please

Today's Date: _____

Patient Name: _____

Age: _____

Please answer the following questions, as they are very important to completing your health history.

Do you ever have any of the following symptoms? Please Print. Please Circle

- | | | |
|--|-----|----|
| 1. Headaches | Yes | No |
| 2. Dizziness | Yes | No |
| 3. Lightheadedness | Yes | No |
| 4. Neckaches or stiffness in the neck | Yes | No |
| 5. Pain or Stiffness in the shoulders | Yes | No |
| 6. Pain in the jaw joint | Yes | No |
| 7. Pain in front of the ears | Yes | No |
| 8. Pain in facial muscles | Yes | No |
| 9. Sore throat | Yes | No |
| 10. Are you easily fatigued or tired at the end of the day | Yes | No |
| 11. Forgetfulness or difficulty in learning new material | Yes | No |
| 12. Ringing and buzzing or other sounds in the ears | Yes | No |
| 13. Feeling of fullness in the ears or sinuses | Yes | No |
| 14. Numbness or tingling of the fingertips | Yes | No |
| 15. Backaches: ___Upper ___Mid ___Lower | Yes | No |
| 16. Clicking sounds from the jaw joint ___Right ___Left | Yes | No |
| 17. Popping sounds from the jaw joint ___Right ___Left | Yes | No |
| 18. Difficulty in opening the mouth fully | Yes | No |
| 19. Difficulty in opening and closing the mouth | Yes | No |
| 20. Pain in teeth: ___Upper ___Lower | Yes | No |
| 21. Pain in, around, or behind eyes | Yes | No |
| 22. Visual problems (eyesight getting worse) | Yes | No |
| 23. Clench teeth during the day | Yes | No |
| 24. Grind teeth at night | Yes | No |
| 25. Frequent stress encounters ___Home ___Work | Yes | No |
| 26. Received orthodontic treatment | Yes | No |
| 27. Wisdom teeth been removed. When _____ | Yes | No |

Under what circumstances did the pain begin? _____

What do you think is the cause of your pain? _____

Are you currently taking any medications for these symptoms?

If yes please list _____

Please list your most severe symptoms (aches, pains, etc.), frequency, duration, severity, and when they started. Start with the most severe symptom.

Symptoms How Often How Long How Severe First Started

1. _____
2. _____
3. _____