

## Page 4 – Office Policy and Signature Section

### By signing below, you understand the following:

- We like having knowledgeable patients and strive to educate patients regarding their current dental condition. We invite you to discuss with us any questions regarding our services or your dental needs.
- The best Dental Health services are based on a friendly, mutual understanding between the provider Dentist and Hygienist and the Patient.
- Office policy requires payment, in full, for all services rendered at the time of the visit.
- We accept All Major Credit Cards, Cash, Checks and offer Extended payments.
- If your account is not paid within 60 days of the date of service, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account – We report to the Credit Bureaus.
- A billing charge is placed on all accounts over 30 days.
- By signing, you understand that Dentistry is **NOT** an exact science and therefore reputable practitioners cannot guarantee results. You also acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment.
- By signing below, you authorize us to perform any necessary services needed during diagnosis and treatment.
- By signing below, you acknowledge that you will not write negatively on any website, or post any negative information whatsoever, regarding any aspect of this dental practice or your dental experience. We like Happy Patients....If you have any problem please see Dr. Gordon. If you like what we do, then be sure to tell your family, friends and co-workers, we appreciate and thank you.
- For patients with Dental Insurance (which requires Claim Forms): you are authorizing the provider to release any information required to process insurance claims.
- By signing below, you understand the above information and guarantee this 4 – page form has been filled out correctly and understand it is your responsibility to inform this office of any changes to the information that you have provided.

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
                   Adult Patient     Parent or Guardian     Spouse

We appreciate your confidence in our ability to treat your dental needs.

This Family-run Dental Practice was started in 1941 by Dr. Wilbert Gordon (my uncle) and then operated for 50 years by Dr. Theodore Gordon (my father). It has always been a leader in the use of High-Technology in a Dental Setting, at a very fair price.

From that day, we have always built and maintained this practice through referrals of fine patients from our satisfied existing patients.

We are always available to help and are grateful for and look forward to your referral of family, friends and co-workers to become new patients in this dental practice.

Thank you, Stephen, Kyle, Sheri, Patty

### Page 3 -- Medical Information:

Are you taking any of the following medications? [ ]Nerve Pills [ ]Pain Pills [ ]Muscle Relaxers [ ]Insulin [ ]Blood Thinners [ ]Tranquilizers [ ]Stimulants [ ] Osteoporosis Medication [ ]Cholesterol Medication  
Please Neatly List Your Medications and Dosage: \_\_\_\_\_

Have been diagnosed or have you had any of the following? Y=Yes N=No

- |                               |                          |                                |                              |
|-------------------------------|--------------------------|--------------------------------|------------------------------|
| Y N Heart Attack / Stroke     | Y N Thyroid Problems     | Y N Cosmetic Surgery           | Y N Cancer / Tumors          |
| Y N Heart Surgery/ Pacemaker  | Y N Kidney Problems      | Y N Shingles                   | Y N X-Ray or Cobalt treatmnt |
| Y N Heart Murmur              | Y N Liver Problems       | Y N Hepatitis: Type?           | Y N Chemotherapy             |
| Y N Rheumatic Fever           | Y N Respiratory Problems | Y N HIV +/-ARC                 | Y N Asthma                   |
| Y N Mitral Valve Prolapse     | Y N Sinus Problems       | Y N Arthritis/Rheumatism       | Y N Difficult Breathing      |
| Y N Artificial Valves         | Y N Stomach Prob/Ulcer   | Y N Artificial Bone/Joint      | Y N Diabetes/Hypoglycemia    |
| Y N Heart Disease             | Y N Psychiatric Problems | Y N Emphysema                  | Y N Leukemia                 |
| Y N Congenital Heart Defect   | Y N Venereal Disease     | Y N Fainting/Seizures/Epilepsy | Y N Anemia                   |
| Y N Chest Pains               | Y N Alcohol/Drug Abuse   | Y N Glaucoma                   | Y N High/Low Blood Pressure  |
| Y N Scarlet Fever             | Y N Tuberculosis TB      | Y N Frequent Neck Pain         | Y N Bleeding Problems        |
| Y N Nervousness               | Y N Jaw Problems TMJ/TMD | Y N Acid Reflux                | Y N Eating Disorder          |
| Y N Severe/Frequent Headaches | Y N Back Problems        | Y N Bulimia                    | Y N Anorexia                 |

Please describe any treatment listed above:

Please list any other surgeries or medical conditions: \_\_\_\_\_

Are you **allergic** to any of the following: [ ]Latex [ ]Penicillin/Amoxicillin [ ]Aspirin [ ]Dental Anesthetics [ ]Other \_\_\_\_\_

Do you use tobacco? [ ]No [ ]Yes/How used? \_\_\_\_\_ How much? \_\_\_\_\_

Please rate your general health from 1 – 10: \_\_\_\_\_

Do you wear contact lenses? [ ]No [ ]Yes

Have you ever taken the drug Phen-Fen and/or Redux? [ ]No [ ]Yes

**For Women:** Are you taking Birth Control Pills? [ ]No [ ]Yes

Are you Pregnant? [ ]No [ ]Yes/How long \_\_\_\_\_

Are you nursing? [ ]No [ ]Yes

### SMILE EVALUATION

1) Are you unhappy with the appearance of your teeth – your smile? [ ] Yes [ ] No

If no, explain: \_\_\_\_\_

2) Do you have spaces that you do not like? [ ] Yes [ ] No

If no, explain: \_\_\_\_\_

3) Are you unhappy with the color of your teeth? [ ] Yes [ ] No

If no, explain: \_\_\_\_\_

4) Are you unhappy with the shape of your teeth? [ ] Yes [ ] No

If no, explain: \_\_\_\_\_

5) Are your teeth... [ ] Chipped? [ ] Protruding? [ ] Crooked? [ ] No

6) Are your teeth wearing down on the biting surface? [ ] Yes [ ] No

7) Are you unhappy with your current fillings / crowns / dental restorations? [ ] Yes [ ] No

If yes, explain: \_\_\_\_\_

8) What would you like to change the most in the appearance of your teeth?

# Page 2 – Dental Information Form

## American Dental Association - Warning Signs of Periodontal Gum Disease

Do not wait until it hurts. We can help reduce these problems.

**WITHOUT SURGERY!**

Periodontal Disease is typically painless. Latest studies show that it affects over 75% of the population and often the victims are unaware of the severity.

- |  |  |                             |
|--|--|-----------------------------|
| 1) Gums that bleed when you brush your teeth?                | <input type="checkbox"/> Yes                             | <input type="checkbox"/> No |
| 2) Gums are red, swollen or tender?                          | <input type="checkbox"/> Yes                             | <input type="checkbox"/> No |
| 3) Gums have pulled away (receded) from the teeth?           | <input type="checkbox"/> Yes                             | <input type="checkbox"/> No |
| 4) Pus between teeth and gums when gums pressed?             | <input type="checkbox"/> Yes                             | <input type="checkbox"/> No |
| 5) Permanent (Adult) teeth are loose or separating (moving)? | <input type="checkbox"/> Yes                             | <input type="checkbox"/> No |
| 6) Change in the way your teeth fit when biting?             | <input type="checkbox"/> Yes                             | <input type="checkbox"/> No |
| 7) A change in the fit of partial dentures?                  | <input type="checkbox"/> Yes                             | <input type="checkbox"/> No |
| 8) Persistent bad breath?                                    | <input type="checkbox"/> Yes                             | <input type="checkbox"/> No |
| 9) Previous Gum / Bone Surgery?                              | <input type="checkbox"/> Yes When: _____ / _____ / _____ | <input type="checkbox"/> No |

**If these warning signs apply to you, bring it to our attention  
Act now, and keep your teeth for a lifetime.**

Reason for today's visit: \_\_\_\_\_

Last Dentist Name and Telephone Number: \_\_\_\_\_

Date of Last Dental Appointment: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Treatment Performed \_\_\_\_\_

List of serious Dental Problems: \_\_\_\_\_

- 1) How often do you brush your teeth? \_\_\_\_\_ per day Floss? \_\_\_\_\_ per [ ]day or [ ]week
- 2) Type of Toothbrush: [ ]Manual [ ]Electric: Brand: \_\_\_\_\_
- 3) Texture of Bristles: [ ]Hard [ ]Medium [ ]Soft
- 4) Teeth Condition: PAIN TO: [ ]Hot [ ]Cold [ ]Sweet [ ]Bite
- 5) Do you CLENCH or GRIND your teeth? When? \_\_\_\_\_
- 6) Do you have a bite guard? [ ]No  
[ ]Yes (type: [ ]Hard Plastic [ ]Soft Rubber [ ]Other \_\_\_\_\_)
- 7) Are you happy with the color of your teeth? [ ]Yes [ ]No
- 8) Would you like to change anything about your teeth? [ ]No [ ]Yes: \_\_\_\_\_
- 9) Would you like WHITER TEETH in about 1 hour? [ ]No [ ]Yes
- 10) Previous Orthodontic Treatment? [ ]No [ ]Yes: Duration of Treatment: \_\_\_\_\_
- 11) Previous Oral Surgery / Extractions? \_\_\_\_\_
- 12) Do you Snore? [ ]No [ ]Yes Do you have a Snore-Reducing Guard? [ ]No [ ]Yes
- 13) Do you have difficulty sleeping, due to Snoring?: [ ]No [ ]Yes
- 14) Do you have Sleep Apnea? [ ]No [ ]Yes-Current Treatment: \_\_\_\_\_
- 15) Have you had a Sleep Study? Details: \_\_\_\_\_
- 16) Do you have sinus infections? [ ]No [ ]Yes How often: \_\_\_\_\_ per? Month / Year
- 17) Are you concerned about your Breath? [ ]No [ ]Yes
- 18) Do you have problems with Dental Anesthetic? [ ]No [ ]Yes: \_\_\_\_\_
- 19) Does Dental Work bother you? [ ]No [ ]Yes/How?: \_\_\_\_\_

Any other problems/concerns you would like to address:  
\_\_\_\_\_

\*\*Do you require Pre-medication with Antibiotic? [ ]No [ ]Yes/Antibiotic: \_\_\_\_\_

How would you rate your smile? 1=Bad to 10=Best \_\_\_\_\_ Why? \_\_\_\_\_

# PAGE 1 – PATIENT INFORMATION

DATE: \_\_\_ / \_\_\_ / \_\_\_

## About You:

Dr./Mr./Mrs./Ms.

Name: \_\_\_\_\_

Name you prefer to be called: \_\_\_\_\_

Home Address: \_\_\_\_\_

\_\_\_\_\_  
City State Zipcode

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Work Address: \_\_\_\_\_

\_\_\_\_\_  
City State Zipcode

Home phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

Cell phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

Work phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

Email: \_\_\_\_\_

Preferred contact method: \_\_\_\_\_

Date of Birth: \_\_\_ / \_\_\_ / \_\_\_

Social Security Number: \_\_\_ / \_\_\_ / \_\_\_

Drivers License #: \_\_\_\_\_

Marital Status: [ ]S [ ]M [ ]D [ ]W

Spouse: \_\_\_\_\_

**Emergency Contact:** Relation: \_\_\_\_\_

Name: \_\_\_\_\_

Home phone #: ( ) \_\_\_\_\_ - \_\_\_\_\_

Work phone #: ( ) \_\_\_\_\_ - \_\_\_\_\_

Cell phone #: ( ) \_\_\_\_\_ - \_\_\_\_\_

Your Medical Doctor: \_\_\_\_\_

Telephone Number: ( ) \_\_\_\_\_ - \_\_\_\_\_

Whom may we thank for referring you:

\_\_\_\_\_  
\_\_\_\_\_

## Method of Payment:

[ ]Cash [ ]Check

[ ]Credit Card:

[ ]Visa [ ]Mastercard [ ]Discover [ ]Amex

Number: \_\_\_\_\_

Expiration Date: \_\_\_ / \_\_\_ / \_\_\_

## Insurance Information:

Primary Insurance Company

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
City State Zipcode

Telephone Number: ( ) \_\_\_\_\_ - \_\_\_\_\_

Group ID Number: \_\_\_\_\_

Plan Number: \_\_\_\_\_

Insured Number: \_\_\_\_\_

Insured Name: \_\_\_\_\_

Relation: \_\_\_\_\_

Date of Birth: \_\_\_ / \_\_\_ / \_\_\_

Employer: \_\_\_\_\_

Please inform us if you have dual insurance.

=====  
For office use only:

Entire 4 page Record Reviewed:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
\_\_\_\_\_