VERODENTAL
TRUE TO YOUR SMILE

Alexander M. Harris, DDS

www.verodental.com

WELCOME

To better serve you, please take a couple of minutes to answer the following questions. Thanks!

What is the most important thing to you about your dental visit today?

Please check any of the following problems that apply to you:

- ☐ Sensitivity (hot, cold, or sweet)
  If so, which teeth? ______
- ☐ Headaches, earaches, neck pain
- ☐ Teeth or fillings breaking
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen, or irritated gums
- ☐ Loose, tipped, or shifting teeth
- ☐ Bad breath
- ☐ N/A

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

☐ Dentures ☐ Partial dentures ☐ Periodontal (gum) treatments ☐ None

Please share the following approximate dates:

Your last cleaning ______ Last oral cancer screening ______ Last complete X-rays ______

Who was your previous dentist?

Name of Practice ______ Name of Provider ______

If you could whiten your teeth, at a cost that anyone could afford, would you like to? ☐ Yes ☐ No

How many times a week do you floss? ______

How many times a day do you brush? ______

If you could change your smile, would you (please check all that apply):

- ☐ Make your teeth whiter?
- ☐ Restorations?
- ☐ Replace old crowns that don't match?
- ☐ Have a smile makeover?
- ☐ Make your teeth straighter?
- ☐ Repair chipped teeth?
- ☐ Replace black metal fillings with tooth-colored fillings?
- ☐ Close spaces between teeth?
- ☐ Replace missing teeth?
- ☐ N/A

On a 1–5 scale, with 5 being the highest rating (please circle the number that best applies):

How important is your dental health to you?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
How would you rate your current dental health?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Where do you want your dental health to be?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Why did you leave your previous dentist? ______

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PATIENT REGISTRATION

Welcome

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. The better we communicate, the better we can care for you.

Name ______________________ Preferred Name ______________________

Gender ☐ Male ☐ Female DOB ______________________ SS # ______________________

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Address ______________________ City ______________________ State ________ ZIP ____________

Email ______________________ Home # ______________________ Mobile # ______________________

Whom may we thank for referring you? ______________________ Other family members seen by us ______________________

Employer ______________________ Years of Employment ____________ Phone # ______________________

Person Responsible for This Account

Name ______________________ Relationship ______________________ DOB ______________________

Email ______________________ Home # ______________________ Mobile # ______________________

Address ______________________ City ______________________ State ________ ZIP ____________

Insurance Information

☐ No Dental Insurance

Insurance Name ______________________ Insurance Phone # ______________________

Insurance Address ______________________ City ______________________ State ________ ZIP ____________

Insured Name ______________________ DOB ______________________ Phone # ______________________

Ins. SS # ____________ Ins. Group # ____________ ID # ____________ Employer ____________

IF YOU HAVE A SECONDARY INSURANCE, PLEASE LET A TEAM MEMBER KNOW.

Emergency Contact Information

Name ______________________ Relation ____________ Home # ____________ Work # ____________

Thank you for filling out this form completely. It will allow us to serve you more effectively. If you have a question at any time, please ask us. We are happy to help.

Our office is HIPAA compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name ____________ Phone # ____________ Last Visit Date ____________

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

Please explain ____________

Please rate your current physical condition ☐ Good ☐ Fair ☐ Poor

Do you smoke or use tobacco in any forms? ☐ Yes ☐ No

Are you currently taking any prescription, over-the-counter, or herbal supplement drugs? ☐ Yes ☐ No

Please list ____________

Have you ever taken phen-fen (also known as Redux® or Pondimin®?) ☐ Yes ☐ No

If yes, when? ____________

Are you taking any medications for osteoporosis? ☐ Yes ☐ No

Are you allergic to any of the following? (please check all that apply):

- Aspirin ☐
- Codeine ☐
- Dental Anesthetics ☐
- Erythromycin ☐
- Jewelry/Metals ☐
- Latex ☐
- Penicillin ☐
- Tetracycline ☐
- Other: ____________
- None ☐

Have you ever had any of the following diseases or medical problems? (please check all that apply):

- Abnormal Bleeding ☐
- Alcohol/Drug Abuse ☐
- Anemia ☐
- Arthritis ☐
- Artificial Bones, Joints, or Valves ☐
- Asthma ☐
- Blood Transfusion ☐
- Cancer/Chemotherapy ☐
- Colitis ☐
- Congenital Heart Defect ☐
- Diabetes ☐
- Difficulty Breathing ☐
- Emphysema ☐
- Epilepsy ☐
- Fainting Spells ☐
- Glaucoma ☐
- Hay Fever ☐
- Heart Attack ☐
- Heart Murmur ☐
- Heart Surgery ☐
- Hemophilia ☐
- Hepatitis ☐
- Herpes/Fever Blisters ☐
- High Blood Pressure ☐
- HIV+/AIDS ☐
- Hospitalization (for any reason) ☐
- Kidney Problems ☐
- Liver Disease ☐
- Low Blood Pressure ☐
- Lupus ☐
- Mitral Valve Prolapse ☐
- Pacemaker ☐
- Psychiatric Problems ☐
- Radiation Treatment ☐
- Rheumatic/Scarlet Fever ☐
- Seizures ☐
- Shingles ☐
- Sickle Cell Disease ☐
- Sinus Problems ☐
- Stroke ☐
- Thyroid Problems ☐
- Tuberculosis (TB) ☐
- Ulcers ☐
- Venereal Disease ☐
- Other: ____________
- None ☐

MEDICAL HISTORY (CONT.)

Do you have trouble sleeping? ☐ Yes ☐ No

Do you feel tired or fatigued after sleep? ☐ Yes ☐ No

Do you feel like you get enough sleep at night? ☐ Yes ☐ No

Do you have a CPAP? ☐ Yes ☐ No

If so, do you wear it? ______________________

For Women Only

Are you taking birth control pills? ☐ Yes ☐ No

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

Disclaimer

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental team to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Print Name ______________________ **Date** ______________

Patient's Signature (Parent's or Guardian's if Minor) ______________________

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.