

Dr. Gary Wessels, Inc.

Comprehensive and Implant Dentistry

Welcome to our office.

Thank you for trusting us with your dental care. Please read and initial in **two** locations below.

What we Believe in

Our Mission is to provide you with excellent quality service and care, with a focus on reducing your risks of dental problems over the long term.

Payment Responsibility.

You are ultimately responsible for payment for all services provided to you.

If you have a dental plan, we will bill your plan on your behalf. If a co-pay or deductible applies, this amount is due at the time of treatment.

Sometimes insurance payments vary from estimates. Any amounts remaining unpaid by your plan after 45 days will be billed to you.

It is your responsibility to track your coverage and be aware of any limits that may apply to your treatment. If you have questions regarding your coverage, we will be happy to assist you.

✓ Please initial here: _____.

Appointments

-When you book an appointment, we reserve time specifically for you.

-We plan for specific treatment steps for each appointment you book with us.

-If you need to make changes, or if you have any questions about your upcoming appointment, please **contact us at least 2 open business days before your appointment** so we can arrange your care to best meet your needs. We are open Monday to Thursday.

-We will send an appointment reminder by phone, e-mail, and / or text message 1-3 days prior to your appointment.

✓ Please initial here: _____.

Welcome to our office! We look forward to serving you.

We collect personal, dental, and medical information to ensure your safety while under our care and to facilitate the highest quality of care for you.

Personal Information

Name _____ Nickname _____

Male Female Adult Child Spouse's Name _____

If Child, Name of Parent(s) or Guardian _____

Address _____ City _____ Postal Code _____

Phone: Home _____ Work _____ Cell _____

E-mail _____ Date of birth (m) _____ (d) _____ (y) _____

(Please place a check mark next to your preferred mode of contact)

How did you hear of our office? _____

<u>Primary Dental Insurance</u>	<u>Secondary Dental Insurance</u>
Name of Insured _____ M <input type="checkbox"/> F <input type="checkbox"/>	Name of Insured _____ M <input type="checkbox"/> F <input type="checkbox"/>
Insurance Co _____	Insurance Co _____
Employer _____	Employer _____
Insured D.O.B. (m) _____ (d) _____ (yr) _____	Insured D.O.B. (m) _____ (d) _____ (yr) _____
Group / Policy # _____	Group / Policy # _____
I.D. # / Cert _____	I.D. # / Cert _____

Name of previous dentist _____ Province / State _____

When was your last dental hygiene appointment? _____

Do you have any food, drug, or environmental allergies? YES NO
If so, please list: _____

(Women) Is there any possibility that you are pregnant? YES NO

Medical History

Do you take any medication, supplement, or homeopathic remedy? YES NO
If so, please list:

Do you have any illnesses or medical conditions? YES NO
If so, please list: _____

Have you been hospitalized in the last 5 years? YES NO
If so, for what reason? _____

Are you being treated for a specific illness right now? YES NO
If so, please list: _____

Have you ever been advised to take antibiotics or "premedication" before dental treatment (due to a pre-existing medical condition)? YES NO

If so, why? _____

Do you take blood thinners? YES NO

Do you bruise easily or bleed abnormally? YES NO

Do you have any artificial joints or valves? YES NO
If so, where and when were these placed? _____

Have you ever had an unusual reaction to drugs or medicines, including dental freezing? YES NO
If so, please list: _____

Have you ever been warned not to take certain medications? YES NO
If so, please list: _____

Have you, in the last 6 months, taken **prescription** steroids or anti-inflammatories for non-dental problems? YES NO

Do you experience shortness of breath upon exertion? YES NO

Have you ever had radiation treatment or chemotherapy? YES NO
If so, please provide details and areas treated: _____

Do you have any head, neck, or back injuries, or pain issues? Is so, please describe _____

Are you often exhausted or fatigued? YES NO

Do you consider yourself a sensitive or touchy person? YES NO

Are you often unhappy or depressed? YES NO

Do you smoke or use tobacco in any form? YES NO

Name of your Physician _____

Date of last medical exam _____

Do you have or have you ever had any of the following? (Check if applicable)

- | | | |
|--|---|--|
| <input type="checkbox"/> Heart disease /attacks | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Osteoporosis / Osteopenia |
| <input type="checkbox"/> Heart defects | <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Digestive disorders (eg Gastric Reflux) |
| <input type="checkbox"/> Prosthetic heart valve(s) | <input type="checkbox"/> Ulcers or stomach problems | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Stroke | <input type="checkbox"/> Hormone Deficiency |
| <input type="checkbox"/> High or Low Blood Pressure | <input type="checkbox"/> Epilepsy / Seizures | <input type="checkbox"/> Alcohol / Drug Dependency |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Rheumatic or Scarlet fever | <input type="checkbox"/> Thyroid / Parathyroid disease |
| <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Herpes /Cold sores |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Venereal diseases | <input type="checkbox"/> Psychiatric care |
| <input type="checkbox"/> Artificial joint(s) | <input type="checkbox"/> autoimmune disease | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Asthma | <input type="checkbox"/> Organ Transplants |
| <input type="checkbox"/> Ear / Nose / Throat disorders | <input type="checkbox"/> Eye disorders | <input type="checkbox"/> Cancer |

If any of the above are circled, please provide details:

Do you have any other disease, condition, or problem not listed?

YES

NO

If so, please list: _____

Please advise us of any future changes in your medications or medical history

I, the undersigned, certify that all of the information provided is true to the best of my knowledge, and I have not knowingly omitted any information. I consent to my physician or pharmacist being contacted, if necessary, to obtain information that is required for my dental care. I authorize Dr. Gary Wessels, Inc. to release information necessary to process insurance claims (if any). I consent to e-mail and text message contact from this office. I understand that I may terminate e-mail or text message communication with this office by replying to either with "Unsubscribe".

Payment is required from you, at the time of service, for your portion of our fees.

Your signature below indicates that you understand and accept this policy.

Signature _____

Date _____

DENTAL HISTORY

Name _____ Nickname _____ Age _____
 Referred by _____ How would you rate the condition of your mouth? Excellent Good Fair Poor
 Previous Dentist _____ How long have you been a patient? _____ Months/Years
 Date of most recent dental exam ____/____/____ Date of most recent x-rays ____/____/____
 Date of most recent treatment (other than a cleaning) ____/____/____
 I routinely see my dentist every: 3 mo. 4 mo. 6 mo. 12 mo. Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

YES NO

PERSONAL HISTORY



1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] _____
2. Have you had an unfavorable dental experience? _____
3. Have you ever had complications from past dental treatment? _____
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____
6. Have you had any teeth removed or missing teeth that never developed? _____

GUM AND BONE



7. Do your gums bleed or are they painful when brushing or flossing? _____
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____
9. Have you ever noticed an unpleasant taste or odor in your mouth? _____
10. Is there anyone with a history of periodontal disease in your family? _____
11. Have you ever experienced gum recession? _____
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? _____

TOOTH STRUCTURE



14. Have you had any cavities within the past 3 years? _____
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____
17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____
18. Do you have grooves or notches on your teeth near the gum line? _____
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____
20. Do you frequently get food caught between any teeth? _____

BITE AND JAW JOINT



21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? _____
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____
25. Are your teeth becoming more crooked, crowded, or overlapped? _____
26. Are your teeth developing spaces or becoming more loose? _____
27. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together? _____
28. Do you place your tongue between your teeth or close your teeth against your tongue? _____
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____
30. Do you clench your teeth in the daytime or make them sore? _____
31. Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth? _____
32. Do you wear or have you ever worn a bite appliance? _____

SMILE CHARACTERISTICS



33. Is there anything about the appearance of your teeth that you would like to change? _____
34. Have you ever whitened (bleached) your teeth? _____
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____
36. Have you been disappointed with the appearance of previous dental work? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____