# Myron L. Gottfried, DDS, PLLC and Haley Gottfried Mann, DDS

## Welcome You to our Office

**MODERN DENTISTRY, OLD FASHIONED CARE**

Today's Date____/____/____ ☐ Male ☐ Female Birthdate: ____/____/____

Patient Name _____
Last First M.I.

Nickname _____ SSN _____

Mailing Address _____ (if PO Box, street address must be completed)

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email _____ Work Phone _____ Ext No _____

Employer _____ Occupation _____

Status ☐ Child ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse's Name _____

Who may we thank for referring you to our office? _____

## Account Information

Person Responsible _____

Relationship to Patient _____

Billing Address _____ (if PO Box, street address must be completed)

City _____ State _____ Zip _____

Street Address _____

City _____ State _____ Zip _____

SSN _____ DL # _____

Home Phone _____ Cell Phone _____

Work Phone _____ Ext No _____

Email Address _____

Anticipated Payment Method ☐ Cash/Check ☐ Credit Card ☐ Will need to make payment arrangements

## Insurance Information

*Primary Insurance*

Company Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Policy / Group # _____

Insured Name _____ SSN _____

Relationship _____ Date of Birth ___/___/___

Employer _____

*Secondary Insurance*

Company Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Policy / Group # _____

Insured Name _____ SSN _____

Relationship _____ Date of Birth ___/___/___

Employer _____

## Emergency Notification Information

For Emergencies, please list a contact that does not live with you _____

Relationship _____

Home Phone No _____

Work Phone No _____

Cell Phone No _____

Who is your Medical Doctor? _____

What Pharmacy do you most frequently use? _____

## Dental Information

Reason for Today's Visit ☐ Exam ☐ Emergency ☐ Consultation

Are you in pain? ☐ No ☐ Yes How long? _____

Please indicate by checking the box, if you are experiencing any of the following problems:

☐ Discomfort, clicking or popping jaw ☐ Red, swollen or bleeding gums ☐ Lost/Broken Filling ☐ Stained Teeth

☐ Sensitive Tooth, teeth or gums ☐ Blisters/Sores in/near mouth ☐ Teeth grinding/clenching ☐ Locking Jaw

☐ Ringing in ears (tinitus) ☐ Broken/Chipped Tooth/Teeth ☐ Bad Breath ☐ Other

Describe Other _____

Do you require antibiotic pre-medication? ☐ Yes ☐ No ☐ Don't Know

Previous Dentist (Name & City/State) _____

Last Dental Exam ____/____/____ Last Dental X-rays ____/____/____

Times/day you brush _____ Times/week you floss _____ Type of brush you use ☐ Soft ☐ Medium ☐ Hard

Please circle how you would rate your smile (worst) 1 2 3 4 5 6 7 8 9 10 (best)

## Medical Information

Do you have, or have you ever had, any of the following (please put a checkmark in front of all that apply):

| Heart Conditions: | Blood Conditions: | Respiratory Conditions: | Psychiatric: | Other: |
|---|---|---|---|---|
| __Attack/Stroke | __Anemia | __Shortness of Breath | __Nervousness | __Thyroid Disorder |
| __Surgery/Pacemaker | __Hypoglycemia | __Asthma | __Substance Abuse | __Rheumatic Fever |
| __Murmur | __Diabetes | __Emphysema | __Depression | __Scarlet Fever |
| __Mitral Valve Prolapse | __Hi/Lo Blood Pressure | __Sinus Infection | __ADD/ADHD | __Shingles |
| __Artificial Valves | __HIV/AIDS/ARC | __Tuberculosis (TB) | | __Glaucoma |
| __Heart Disease | __Hepatitis | | | __Seizure/Epilepsy |
| __Chest Pain | | | | __Venereal Disease |
| __Congenital Defect | | | | __Cosmetic Surgery |

| Head/Neck: | Bone/Joint: | Cancer/Tumor: | Digestive: |
|---|---|---|---|
| __Jaw Pain/Difficulty | __Arthritis / Rheumatism | __Chemotherapy | __Ulcer |
| __Severe/frequent headache | __Artificial Bones/Joints | __X-ray or Cobalt Treatment | __Kidney |
| __Severe/frequent neck pain | __Back pain/problems | __Leukemia | __Liver |

Please list any other medical condition(s) you have, or have had, or any additional information concerning any conditions you have checked above (attach additional sheet if necessary):

Please list any medical allergies you are aware that you have (attach additional sheet if necessary):

Please list any medications you are taking (attach additional sheet if necessary):

Do you use tobacco? ☐ No ☐ Yes / How Used? _____ How much? _____ How long? _____

Please rate your general health from 1 (poor) - 10 (very good) _____ Do you wear contact lenses? ☐ Yes ☐ No

Have you ever taken the drug Phen-fen and/or Redux? ☐ Yes ☐ No

***For Women Only:*** Are you taking Birth Control pills? ☐ Yes ☐ No How many children have you had? _____

Are you Pregnant? ☐ No ☐ Yes / How far along? _____ Are you nursing? ☐ Yes ☐ No

## Policy and Agreement

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 business manager. 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, collection agency fees, interest charges and any other expenses incurred in collecting your account.

Your signature below signifies the following: 1) authorizes staff to perform any necessary services needed during diagnosis and treatment. 2) authorizes staff to release any information required to process insurance claims. 3) you understand the above information and guarantee this form was completed correctly, to the best of your knowledge and 4) you understand it is your responsibility to inform this office of any changes to this information.

Signature _____ Date ____/____/____

☐ Adult Patient ☐ Parent or Guardian ☐ Spouse