Charles J. Boettcher, DDS - 5/9/2024

Patient Name

First Name	Last Name

Step 1

Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Prefers to be called	Birthdate	Age	Gender
Social Security#	Mailing Address	City	State
Zip	Home Phone	Cell Phone	Email
Referred By	Employer	Occupation	How long?

Employer Address	Employer Phone

Status:

Single	Married	Widowed	Separated

Divorced	Spouse's Name	Children

Person Responsible for Account	Relation

Notify in Case of an Emergency	Relation	Home Phone

Cell	Work

Step 2

Dental Insurance

Do you have dental insurance?

Do you have a dental insurance card?	Company name:	Is this insurance:	Who is the employer?

Who works for this employer?	Employee's date of birth

Employee's Social Security #

Secondary Dental Insurance

Do you have secondary dental insurance?

Do you have a dental insurance card?	Company name:	Is this insurance:	Who is the employer?
Who works for this employer?		Employee's date of birth	
Employee's Social Security #			

Step 3

Dental History

Reason for today's visit		Are you in dental discomfort today?	Former Dentist
Date of last dental care		Rate your smile:	

Are you experiencing any of the following:

Bad breath	Bleeding gums	Sensitivity to: Sweets/Chewing/Hot/Cold	Food collection between teeth
Grinding or clenching teeth	Periodontal treatment	Jaw joint clicks/Pops/Painful	Loose teeth or broken fillings
Sores/growths in mouth			

Medical History

Physician's name	Address	Phone	Have you had any serious illnesses or operations?

Women:

Are you pregnant?	Nursing?	Taking birth control pills?	Do you require antibiotic premedication prior to dental treatment?
Do you use tobacco?	Type	How much?	How long?

Have you had or are you having any of the following:

AIDS/HIV Positive	Acid reflux/acid in mouth	Alcohol/Drug Abuse	Anaphylaxis/Epipen
Artificial heart valves	Artificial joints	Asthma/Respiratory Disease	Blood thinners/anticoagulant
Cancer	Chemotherapy	Circulatory problems	Dementia
Diabetes	Epilepsy	Fainting/Seizures	Food Allergy
Headaches	Heart Murmur	Heart Problems	Hemophilia/Abnormal bleeding
Herpes/Cold sores	Hepatitis ABC	High blood pressure	Latex allergy
Liver disease	Mitral Valve Prolapse	Osteoporosis Treatment	Pacemaker/ Heart Surgery

Psychiatric Care	Radiation treatment	Rheumatic heart disease	Stroke
Tuberculosis	Anxiety during dental treatment	Please list any other surgeries or medical conditions you have or have ever had:	
Please list all medications or provide list:			

Allergic to:		
Penicillin/Amoxicillin	Other Antibiotics	Medications

Step 4

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist. I authorize the staff to perform any necessary services needed during diagnosis and treatment.

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Payment is due in full at time of treatment unless prior arrangements have been approved. If account is not paid within 90 days of the date of service and no financial arrangements have been made, I will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

Signature

Date

Payment is due in full at time of treatment unless prior arrangements have been approved.