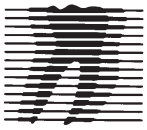
Bradley J. Gerdes, D.D.S.

Family & Cosmetic Dentistry

H E A L T H H I S T O R Y & R E G I S T R A T I O N



Patient's Name _____ Today's Date _____

Birthdate _____ Age _____ Sex: ☐ M ☐ F

Home Address _____

City _____ State _____ Zip _____

Home Phone _____ Work _____ Cell _____

Email Address _____

Name of Spouse (Parent if minor) _____

Are you a full time student? ☐ Yes ☐ No Name of School _____

Your Employer _____ How long employed _____

Occupation _____

How were you referred to our office? _____

Reason for this visit _____

In Case of Emergency Contact

Name _____ Relationship _____

Home Phone _____ Work Phone _____ Cell Phone _____

Account Information

Do you have dental insurance? ☐ Yes ☐ No

Insured's Name _____ Birth Date _____

Name of Employer _____

Name of Insurance Company _____

Social Security Number / ID Number _____ Group Number _____

Do you have double insurance Coverage? ☐ Yes ☐ No

Insured's Name _____ Birth Date _____

Name of Employer _____

Name of Insurance Company _____

Social Security Number / ID Number _____ Group Number _____

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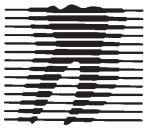

Dental History

1. Have you seen a dentist regularly? ☐ Yes ☐ No
   If yes, date of last visit?_____
2. Were x-rays taken? ☐ Yes ☐ No
3. Are you presently in any dental pain? ☐ Yes ☐ No
4. What concerns you most about your teeth? _____
   _____
5. Do you have any areas in your mouth where food gets trapped? ☐ Yes ☐ No
6. Do you gag easily? ☐ Yes ☐ No
7. Are you apprehensive about dental treatment? ☐ Yes ☐ No
8. Have you had bad dental experiences in the past? ☐ Yes ☐ No
9. Have your wisdom teeth been removed? ☐ Yes ☐ No
10. Have you ever lost or chipped any teeth? ☐ Yes ☐ No
11. Have there been any injuries to face, mouth or teeth? ☐ Yes ☐ No
12. Is any part of your mouth sensitive to temperature? ☐ Yes ☐ No
    Where? _____
13. Is any part of your mouth sensitive to pressure? ☐ Yes ☐ No
    Where? _____
14. Do your gums bleed when you brush? ☐ Yes ☐ No
15. Do you have any type of thumb or tongue habit? ☐ Yes ☐ No
16. Are you a mouth breather? ☐ Yes ☐ No
17. Have you ever seen an orthodontist? ☐ Yes ☐ No
    If so, who and when?_____
18. Do your teeth or jaws ever feel uncomfortable when you awake in the morning? ☐ Yes ☐ No
19. Are you aware of your jaw clicking or popping? ☐ Yes ☐ No
20. Are you aware of clenching your teeth during the day? ☐ Yes ☐ No
21. Have you ever been told that you grind your teeth? ☐ Yes ☐ No
22. Do you have "tension" headaches? ☐ Yes ☐ No
23. Have you ever experienced chronic ringing in your ears? ☐ Yes ☐ No
24. Have you ever had:
    - ☐ Gum treatment
    - ☐ Dentures/partials
    - ☐ Root canals
    - ☐ Teeth extracted
    - ☐ Bridges
    - ☐ Orthodontic treatment
25. Do you have headaches, earaches, neck pains? ☐ Yes ☐ No
26. Are you unhappy with the appearance of your teeth? ☐ Yes ☐ No
27. Would you like your smile to look better or different? ☐ Yes ☐ No
28. Is there any other medical or dental information that you feel we should know about?_____
    _____

Release

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and other treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist, otherwise payable to me.

I understand that my dental care insurance carrier or payor of my dental benefits may pay less that the actual bill for services. I understand that I am financially responsible for payments in full for all accounts. I further understand that a finance charge will be added to any overdue balance. If we have to refer you to a collection agency, you agree to pay all of the collection costs which are incurred.

I understand that a 24 hour notice is required to change appointments. Failure to do so may result in a missed appointment charge.

I attest to the accuracy of the information on this page.

Patient's or Guardian's Signature _____ Date: _____