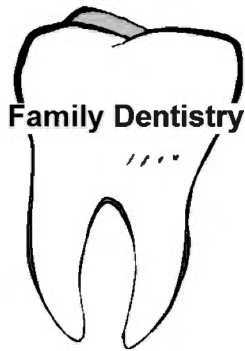


**W. Keith deJong, DDS**
**Kerry T. Plaisance, Jr., DDS**

# WELCOME

Thank you for selecting our DENTAL TEAM! We will always offer you the most up to date care available. To help us meet your dental needs, please fill out these forms for us. Thank you for your assistance.

## PATIENT INFORMATION

Today's Date____________

Name ________________________________ S.S.# ______________ Birth Date ____________
Wish to be called ________________________________ ☐ Male ☐ Female ☐ Single ☐ Married
Address ______________________________________________________________________
City/State/Zip ___________________________________________________________________
Home Phone _________________________ Work Phone ____________________ Ext ______
Your Employer _____________________________ Your Occupation ____________________
Insurance Company Name ______________________________ Date of coverage___________
Name of spouse _________________________________________ Birth Date _____________
Spouse employed by __________________________________________ S.S.#______________
Name of spouse's dental insurance company _________________________________________
Whom may we thank for referring you to our office? ____________________________________
Which Dr. do you wish to see (circle one) ☐ Dr. deJong ☐ Dr. Plaisance ☐ Either

## RESPONSIBLE PARTY

Name of person responsible for this account _________________________________________
Relationship to patient _______________________________ Home Phone_________________
Address ______________________________________________________________________
Email ____________________________________________ Cell Phone _________________
Drivers License#______________________ Birth Date ____________ S.S.#_______________
Employer ____________________________________ Work Phone ______________ Ext _____
Is this person currently a patient of our office? ☐ YES ☐ NO
For your convenience we offer the following methods of payment. Please check the option you prefer. Your payment is due in full at each appointment, unless prior arrangements have been made.
☐ Cash ☐ Personal Check ☐ Credit Card ☐ I wish to discuss other payment options

## HOW CAN WE CONTACT YOU

Cellular Phone _______________________________ Pager ____________________________
Email ________________________________________________________________________
Where do you prefer to receive calls? ☐ Home ☐ Work ☐ Cellular ☐ Pager
When is the best time to reach you? Time ____________ Days ☐ M ☐ T ☐ W ☐ T ☐ F
Please list name and phone number of someone who will know how to reach you in case of an emergency.
Name ___________________________________________ Phone # _____________________

Name________________________ Date________________

# DENTAL CONCERNS

## WHAT DID YOU NOT LIKE ABOUT YOUR PAST DENTAL APPOINTMENTS?

Was the treatment uncomfortable? ☐YES ☐NO
Was the staff unfriendly? ☐YES ☐NO
Were the fees not explained before your appointments? ☐YES ☐NO
Anything we have not thought of? ____________________________________

## WHAT ARE YOUR FEELINGS ABOUT YOUR:

**FRONT TEETH**

Are you happy with their color? ☐YES ☐NO
Are you happy with their length? ☐YES ☐NO
Are they crowded or crooked? ☐YES ☐NO
Are you happy with their overall appearance? ☐YES ☐NO
Anything about them you would change? ______________________________

**BACK TEETH**

Are they sensitive to hot or cold foods? ☐YES ☐NO
Do they trap food when you eat? ☐YES ☐NO
Anything about them you would change? ______________________________

**GUMS**

Do they ever bleed? ☐YES ☐NO
Are they sensitive? ☐YES ☐NO
Have you ever seen a periodontist (gum specialist)? ☐YES ☐NO
If yes, whom? ___________________________________
Do you feel you have bad Breath? ☐YES ☐NO
Anything about them you would change? ______________________________

**MISSING TEETH**

Do you have any missing teeth? ☐YES ☐NO
Are you wearing a replacement? ☐YES ☐NO
Is your replacement uncomfortable? ☐YES ☐NO
Anything about it you would change? ______________________________
OVERALL: on a scale of 1→ 10, how would you rate the health of your teeth?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

## WHAT IS THE FIRST THING YOU WOULD LIKE US TO HELP YOU WITH?

______________________________________________________________

# MEDICAL CONCERNS

We understand that you are here for us to help you care for your teeth and gums. Medications you are taking and health problems you may have could make a difference in how we treat your dental problems. This information is very important. Thank you in advance for you cooperation. Indicate which of the following you have had or have at the present.

**HEART PROBLEMS**

| | |
|---|---|
| Heart Disease / Attack | ☐ YES ☐ NO |
| Heart Failure | ☐ YES ☐ NO |
| Angina Pectoris | ☐ YES ☐ NO |
| Congenital Heart Disease | ☐ YES ☐ NO |
| Heart Murmur | ☐ YES ☐ NO |
| High Blood Pressure | ☐ YES ☐ NO |
| Arteriosclerosis | ☐ YES ☐ NO |
| Mitral Valve Prolapse | ☐ YES ☐ NO |
| Artificial Heart Valve | ☐ YES ☐ NO |
| Heart Pacemaker | ☐ YES ☐ NO |
| Heart Surgery | ☐ YES ☐ NO |
| Rheumatic Fever | ☐ YES ☐ NO |
| Stroke | ☐ YES ☐ NO |

**BLOOD PROBLEMS**

| | |
|---|---|
| Blood Transfusion | ☐ YES ☐ NO |
| Hemophilia | ☐ YES ☐ NO |
| Anemia | ☐ YES ☐ NO |
| Sickle Cell Disease | ☐ YES ☐ NO |
| Bruise Easily | ☐ YES ☐ NO |

**GASTROINTESTINAL**

| | |
|---|---|
| Ulcers | ☐ YES ☐ NO |
| Diabetes | ☐ YES ☐ NO |
| Thyroid Problems | ☐ YES ☐ NO |
| Liver Disease | ☐ YES ☐ NO |
| Yellow Jaundice | ☐ YES ☐ NO |
| Hepatitis A | ☐ YES ☐ NO |
| Hepatitis B | ☐ YES ☐ NO |
| Hepatitis C | ☐ YES ☐ NO |

**MUSCLES / BONES**

| | |
|---|---|
| Arthritis | ☐ YES ☐ NO |
| Rheumatism | ☐ YES ☐ NO |
| Jaw Joint Pain | ☐ YES ☐ NO |
| Cortisone Medication | ☐ YES ☐ NO |
| Artificial Joints (hips, knee, etc) | ☐ YES ☐ NO |

**BREATHING PROBLEMS**

| | |
|---|---|
| Emphysema | ☐ YES ☐ NO |
| Chronic Cough | ☐ YES ☐ NO |
| Tuberculosis | ☐ YES ☐ NO |
| Asthma | ☐ YES ☐ NO |
| Hay Fever | ☐ YES ☐ NO |
| Allergies or Hives | ☐ YES ☐ NO |
| Sinus Trouble | ☐ YES ☐ NO |
| Sleep Breathing Disorder | ☐ YES ☐ NO |

**GENERAL CONCERNS**

| | |
|---|---|
| Kidney Trouble | ☐ YES ☐ NO |
| Venereal Disease | ☐ YES ☐ NO |
| A.I.D.S | ☐ YES ☐ NO |
| H.I.V. Positive | ☐ YES ☐ NO |
| Epilepsy or Seizures | ☐ YES ☐ NO |
| Fainting or Dizzy Spells | ☐ YES ☐ NO |
| Psychiatric Treatment | ☐ YES ☐ NO |
| Drug Dependence | ☐ YES ☐ NO |
| Radiation Therapy | ☐ YES ☐ NO |
| Chemotherapy | ☐ YES ☐ NO |
| Glaucoma or Eye Surgery | ☐ YES ☐ NO |
| Ever take Fen-Phen | ☐ YES ☐ NO |
| Tobacco Habit | ☐ YES ☐ NO |

Are you under a Physician's care at this time ☐ YES ☐ NO

For what condition? ____________________ Physician's Name ____________

**Please list any medication you are now taking (including over the counter medications)**

________________________________________________________________

**Have you ever had an allergic reaction to anything? ☐ Penicillin ☐ Codeine ☐ Latex ☐ Other______________________**

**FOR WOMEN ONLY**

Are you pregnant? ☐ YES, what month ______________ ☐ NO Are you nursing? ☐ YES ☐ NO

Are you taking birth control pills? ☐ YES ☐ NO

## CONSENT

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

The undersigned hereby authorizes Dr. deJong and/or Dr. Plaisance to take X-Rays, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. deJong and/or Dr. Plaisance to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. deJong and/or Dr. Plaisance to perform any and all forms of treatment, medication and therapy that may be indicated in connection with (name) ________________________ and further authorize and consent that Dr. deJong and/or Dr. Plaisance choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk. I understand the reasonability of payment for Dental Services provided in this office for myself or my dependents are mine, due and payable at the time services are rendered unless financial arrangements have been made.

Patient ____________________________________________ Date ______________