Lori M. Sadar, D.D.S.

WELCOME!

Today's Date: _____ Please give us some information about YOU:

Mr. Mrs. Ms. Miss. Dr. _____
Last First Middle

Nickname: _____ Date of Birth: _____

Home Address: _____
Street City State Zip

Mailing Address: _____
Street/P.O. Box City State Zip

Telephone: (H): _____ (W) _____ (Cell) _____

Best Phone Number to Verify Dental Appointments During Business Hours: _____

Social Security Number: _____ (this is needed to verify your benefits)

Employer: _____
Name Mailing Address City State Zip Code

Whom May We Thank For Referring You: _____

Name & Address Of Nearest Relative Not Living With You: _____

_____

ABOUT YOUR FAMILY:
(Other Family Members)

_____	_____	_____	_____
Name	DOB	Name	DOB
_____	_____	_____	_____
Name	DOB	Name	DOB

BILLING INFORMATION:

Who is Responsible for Payment of Account? _____

Relationship to Patient: _____ **Employer:** _____

Home Address: _____

Street *City* *State* *Zip Code*

Work Phone: _____ *Home Phone:* _____

SS#: _____ *Is This Person a Patient in Our Office?* ☐ *Yes* ☐ *No*

For Your Convenience, We Offer the Following Methods of Payment. Please Check your Preference:

☐ *Cash* ☐ *Personal Check* *Credit Card:* ☐ *Visa* ☐ *Master Card* ☐ *American Express*

INSURANCE INFORMATION:

Name of Insured: _____ *Date of Birth::* _____

Insurance Company: _____ *Group #:* _____

Policy/ID#: _____ *Ins. Co. Address:* _____

How Much is Your Deductible? _____ *Maximum Annual Benefit?* _____

Have you seen another dentist? ☐ *Yes* ☐ *No When?* _____

What did you have done? _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ *Yes* ☐ *No If yes, Complete the Following:*

Name of Insured: _____ *Relationship to Patient:* _____

Birth Date: _____ *SS#:* _____

Name of Employer: _____ *Work Number:* _____

Insurance Company: _____ *Group #:* _____ *Policy/ID #:* _____

Patient Name: _____ **Date:** _____

DENTAL HISTORY: **Please Circle**

Do you have a specific dental problem/concern? Describe: _____ YES NO
_____
Do you have dental examinations on a regular basis? Last Visit: _____ YES NO
Would you describe your present dental health as good? YES NO
Comments: _____
Do you think you have active decay or gum disease? _____ YES NO
Do your gums ever bleed? _____ YES NO
Do you brush and floss on a regular basis? _____ YES NO
Do you feel nervous about having a dental treatment? _____ YES NO
Have you ever had a bad experience in a dental office? Describe: _____ YES NO
_____
Do you want to keep your remaining teeth? _____ YES NO
Do you like the way your teeth look? _____ YES NO

Name of previous dentist (optional): _____ Who referred you to us? _____
Do you ever brux, clench or grind your teeth? _____ YES NO
Have you ever worn braces? When? _____ YES NO
Do you ever have clicking, popping or discomfort in your jaw joints?: _____ YES NO

MEDICAL HISTORY:

Medical doctor's name: _____
Are you under a doctor's care now? Why? _____ YES NO
Have you been hospitalized during the past 2 years? Why? _____ YES NO
Are you taking any medications, pills or drugs? Why? _____ YES NO
Are you allergic to any medications or substance? What? _____ YES NO
Are you pregnant or think you might be? _____ YES NO

Please CIRCLE if you have ever had any of the following:

Heart Trouble	Chest Pain	Scarlet Fever	Cancer	Hypoglycemia
High Blood Pressure	Shortness of Breath	Asthma	Thyroid Disease	Psychiatric Care
Low Blood Pressure	Swelling of Feet/Ankles/hands	Hay Fever	Parathyroid Disease	Drug Addiction
Heart Murmur	Fainting or Dizziness	Sinus Trouble	X-Ray or Cobalt Tmt.	Anemia
Blood Transfusion	Rheumatic Fever	Stroke	Emphysema	Hemophilia
AIDS	Chemotherapy/Radiation	Herpes	Pain in jaw joints	Allergies
Heart Pacemaker	Artificial Heart Valve	Heart Surgery	Artificial Hip/Joints	Liver Disease
Hepatitis A	Hepatitis B	Hepatitis C	Epilepsy	Seizures

SMILE ANALYSIS

NAME: _____ DATE: _____

When you see your smile in the mirror, do you like the way your teeth look?	YES	NO
Is there something about your teeth you would like to change?	YES	NO
Do you have:		
Discolored teeth?	YES	NO
Chipped or worn edges?	YES	NO
Spaces or gaps between your teeth?	YES	NO
Crooked teeth?	YES	NO
Too much gum showing?	YES	NO
Dark/Silver fillings?	YES	NO
Caps or crowns you are unhappy with?	YES	NO
Any other concerns/complaints?	YES	NO
Would you like to whiten your teeth?	YES	NO
Have you ever seen teeth TOO white?	YES	NO
Do you have habits that might discolor your teeth?	YES	NO

Describe: _____

Do you clench or grind your teeth?	YES	NO
Are you interested in information about halitosis or bad breath?	YES	NO
Is there anything that would hold you back from enhancing the look of your teeth?	Yes	No

If Yes, What? _____

_____ _____

Lori M. Sadar, D.D.S. Date