

# WELCOME TO OUR OFFICE!!

## Dr. Lee Zuidema and Staff

Today's Date: \_\_\_\_\_

Home Phone #: \_\_\_\_\_

Work Phone #: \_\_\_\_\_

Cell Phone#: \_\_\_\_\_

### 1. About You....

Name: \_\_\_\_\_  
First Middle Last

Preferred Name: \_\_\_\_\_  Male  Female  
 single  married  divorced  widowed  separated

Home Address: \_\_\_\_\_  
City State Zip Code

Where and when are the best times to reach you?  work  a.m.  
 home  p.m.

Birthday: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_  
City State ZipCode

Occupation: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Other family members seen by us:  spouse  children  parents  siblings

Names: \_\_\_\_\_  
\_\_\_\_\_

In the event of an emergency, whom should we contact?

Their name: \_\_\_\_\_ Phone# \_\_\_\_\_

To protect your health...and the health of your family...

**Our office follows the most up-to-date methods of sterilization and infection control!**

The benefits of a healthy smile are immeasurable!!

Our goal is to help you comfortably reach and maintain maximum oral health.

Please fill out these forms completely so that we can better care for you.

## 2. Dental Insurance

Do you have dental insurance?     yes     no

Insured Name: \_\_\_\_\_

Insured SS# \_\_\_\_\_

Insured Date of Birth: \_\_\_\_\_

Insured Employer: \_\_\_\_\_

Insurance Co. name: \_\_\_\_\_

Insurance Co. address: \_\_\_\_\_

Insurance Co. Phone#: \_\_\_\_\_

Group # (plan, local, or policy ): \_\_\_\_\_

### Secondary Dental Insurance:

**If your spouse has dental insurance and you are covered under the policy, please complete the following:**

Insurance Co.  
Name: \_\_\_\_\_

Insurance Co. address: \_\_\_\_\_

Insurance Co. phone #: \_\_\_\_\_

Group # (plan, local, or policy#): \_\_\_\_\_

Spouse's name: \_\_\_\_\_

Spouse's birthday: \_\_\_ / \_\_\_ / \_\_\_    SS#: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_

Please list other family members covered by this dental insurance:

**Your dental insurance policy is an agreement between you and the insurance company. We will be glad to assist you in preparing and submitting the necessary forms for these benefits.**

## AUTHORIZATION

I hereby authorize payment directly to Dr. Lee Zuidema of the group insurance benefits, otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals. **In the event that a health care worker comes in contact with my blood or other potentially infectious bodily fluids while treating me, I hereby consent to a hepatitis and HIV antibody test. These tests will be at no charge to myself.**

X \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_  
(signature)

# MEDICAL AND DENTAL QUESTIONNAIRE

## 3. Medical History



Patient's Name: \_\_\_\_\_

Physician's name: \_\_\_\_\_

Phone #: \_\_\_\_\_ date last seen: \_\_\_\_/\_\_\_\_/\_\_\_\_

Your current physical health is:     good    fair    poor

Are you currently under the care of a physician?    yes    no

Please explain: \_\_\_\_\_

Are you taking any prescription or over the counter drugs?

yes    no   Please list each one and it's use:

\_\_\_\_\_

\_\_\_\_\_

Are you allergic to any of the following? (circle yes)

- |                        |     |
|------------------------|-----|
| Novocain / Epinephrine | yes |
| Penicillin             | yes |
| Tetracycline           | yes |
| Erythromycin           | yes |
| Codeine                | yes |
| Sulfa                  | yes |
| Aspirin                | yes |
| Dental Anesthetics     | yes |
| Latex                  | yes |
| Metals                 | yes |
| Acrylic                | yes |

Please list any other drugs/ foods/ compounds that you are allergic to:

\_\_\_\_\_

\_\_\_\_\_

**For Women:**

- Are you taking birth control pills?     yes
- Are you pregnant?                             yes (week #\_\_\_\_)
- Are you nursing?                               yes

**For Men:**

- Do you take nitroglycerin ?                 yes
- Are you taking Viagra?                       yes

Have you ever had any of the following diseases or medical problems?(circle yes)

- |                         |     |
|-------------------------|-----|
| Heart attack/stroke     | yes |
| Heart murmur            | yes |
| Heart surgery           | yes |
| Congenital heart def    | yes |
| Mitral Valve Prolapse   | yes |
| Pacemaker               | yes |
| Rheumatic fever         | yes |
| High blood pressure     | yes |
| low blood pressure      | yes |
| Artificial valves       | yes |
| <br>                    |     |
| Hemophilia/blood dis.   | yes |
| Blood transfusions      | yes |
| HIV + / AIDS            | yes |
| Anemia                  | yes |
| <br>                    |     |
| Tuberculosis            | yes |
| Asthma                  | yes |
| Difficulty breathing    | yes |
| Emphysema               | yes |
| <br>                    |     |
| Radiation               | yes |
| Cancer/Chemo Th.        | yes |
| Shingles                | yes |
| Kidney Problems         | yes |
| Artificial bones/joints | yes |
| Diabetes                | yes |
| Hepatitis               | yes |
| Psychiatric problems    | yes |
| Epilepsy/seizures       | yes |
| Cold sores/ Herpes      | yes |
| Drug/alcohol addict.    | yes |
| Venereal disease        | yes |
| Ulcers/ colitis         | yes |
| Arthritis               | yes |
| Frequent headaches      | yes |
| Sinus problems          | yes |
| Hospitalized            | yes |
| Glaucoma                | yes |

Please list any serious medical condition(s) past or present:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## 4. Dental History

Why have you come to the dentist today?

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Are you currently in pain?  no  yes

Have you ever had a serious/difficult problem associated with any previous dental work?  no  yes

If "yes", please describe:

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Your current dental health is:  Good  Fair  Poor

Do you like your smile?  yes  no

Do your gums ever bleed?  yes  no

How many times a week do you floss?  
 0  1-3  4-6  Daily

How many times a day do you brush?  
 0  1  2  3 or more

Type of bristles?  hard  med.  soft

Have you been told or are you aware that you have a tendency to snore?  
 yes  no

Do you wake frequently at night?  yes  no

Do you wake up in the morning feeling tired?  
 yes  no

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

\_\_\_\_\_  
signature

\_\_\_\_\_  
date

## 5. Cosmetics Cosmetics

Do you like the color of your teeth?  no  yes

Do you like the shape and size of your teeth?  
 no  yes

Are you happy with the alignment of your teeth?  
 no  yes

What is it that you wish could be changed to improve your smile?

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## 6. TMJ

Do you have a clicking, popping, or grating noise in your right or left jaw joint?

no  yes

Has the noise changed since it began?

no  yes

Do you have pain when you chew?  no  yes

Do you have pain when you open wide?  no  yes

When did you first notice the pain or noise?

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Has your mouth ever locked open or closed?

no  yes

Do you grind your teeth?  
 no  yes

Have you had a change in your lifestyle such as a change in marital status, childbirth, death in the family, or other stressful events?

no  yes