



DAVID WARD DMD
~ Empowering people to smile. ~

*We will have more personal time together
if you print this form, complete it,
and bring it with you to...*

Your answers to this confidential questionnaire will help us provide the highest quality care available.

Tell us about YOU...



Full Name _____
 Address _____
 City _____ State _____ Zip _____
 Date of Birth _____ S.S. Number _____
 Employer _____ How Long? _____
 Occupation _____ Marital Status _____
 Phone #'s: Home _____ Cell _____
 Work _____ Pager _____
 E-mail _____
 Whom may we thank for referring you? _____

Please describe your dental condition ...

What is your primary dental concern or goal ? _____

Circle any of the following that have recently caused pain or sensitivity to your teeth:

COLD HEAT SWEETS TOUCH CHEWING SPONTANEOUS

Do you clench or grind your teeth, or think you might? Yes No

Do your gums bleed when you brush or floss? Yes No

Have your gums receded? Yes No

Have you noticed any loose teeth? Yes No

Have you had any periodontal (gum) surgery? Yes No

Would you say that you have had a minimal, moderate, or major amount of previous dental treatment?

Would you guess that you *need* a minimal, moderate, or major amount of dental treatment now?

Would you say that you have a low, moderate, or high susceptibility to cavities?

Do you have any crowns (caps) or bridgework? Yes No If yes, how many? _____

Have you ever had any braces or retainers? Yes No

Have you had any permanent teeth extracted (other than wisdom teeth)? Yes No About how many? _____

Please describe any other dental information that may be important to us: _____

think about this...

Please consider the following three goals for your dental treatment. All are all important, Yet not always compatible. Circle the one that seems most important for you:

LONGEVITY

CONSERVING ENAMEL

MINIMAL COST

Your medical information...

Physician's Name _____ Specialty _____

Street _____ City _____

Are you being treated by a physician now? Yes No For what reason(s)? _____

Are you taking any medications at the present time? Yes No Which medications? _____

Will you possibly take any recreational drugs in the 48 before any dental treatment? Yes No

Are you sensitive or allergic to any medications? Yes No Which medicine(s)? _____

Have you ever been hospitalized? Yes No List reasons and dates: _____

Health Questions...

HAVE YOU EVER HAD:

Asthma Yes No

Allergies or Hives Yes No

Tuberculosis Yes No

Stroke Yes No

Heart Disease or Attack Yes No

Angina Pectoris Yes No

High Blood Pressure Yes No

Pacemaker Yes No

Heart Murmur Yes No

Rheumatic Fever Yes No

Mitral Valve Prolapse Yes No

Joint Replacement Yes No

Latex Sensitivity Yes No

Arthritis Yes No

Kidney or Bladder Disease Yes No

Hepatitis, Cirrhosis, Liver Disease Yes No

Epilepsy or Seizures Yes No

Fainting or Dizzy Spells Yes No

Diabetes Yes No

Blood Transfusion Yes No

Abnormal Bleeding Tendencies Yes No

HIV Infection or AIDS Yes No

Sickle Cell Disease or Trait? Yes No

Stomach or Intestinal Ulcers Yes No

Chemo or Radiation Treatment Yes No

Women: Are you Pregnant? Yes No

in case of Emergency, contact...

Name _____ Relation _____ Home Phone _____

Address _____ Work Phone _____

about your diet and such...

Circle the word that best describes your major meals: HEALTHY AVERAGE POOR

Do you drink coffee, tea, soda? YES NO If yes, about how much per day? _____

Do you chew gum? YES NO Chew ice or hard candies? YES NO

Eat lemons? YES NO

Do you use any form of tobacco? YES NO What form and for how long? _____

about your home dental care...

Circle the type of toothbrush you use: ELECTRIC MANUAL

How many times a day do you brush? _____ For how Long? _____

Toothpaste: _____ Mouthwash: _____

Circle how often you floss? DAILY WEEKLY RARELY NEVER

Ever notice any bleeding when brushing or flossing? _____

complete this section if someone other than the patient is responsible for payment...

Responsible Person's Full Name _____

Address _____ City _____ State _____ ZIP _____

Relationship to Patient _____ Home Phone _____ Work Phone _____

Employer _____ How Long _____ Occupation _____

Date of Birth _____ S.S. Number _____ Martial Status _____

dental insurance?

Patient's Relationship to Insured Employee

Full Name of Insured Employee

Insurance Company Policy #

My Signature acknowledges that:

*The questions have been answered truthfully and completely,
Photographs of me may be used for educational purposes,
I understand the office policy with keeping appointments,
I have received a copy of the Notice of Privacy Practices, and
I understand and will comply with the office Financial Policy.*

Patient's Signature (or Parent if a minor)

Date

Thank YOU!

Financial

- 1. If you have any questions about fees for planned treatment, please ask us because it is your right to have any questions answered.**
- 2. We request payment in full at time of treatment. We accept cash, checks and major credit cards (visa, master card and discover).**
- 3. Payment Options:** Our office offers the following additional choices for your convenience.
 - Up to 18 months interest – free financing through Care Credit and Capitol One. Credit limitations may apply.
 - 5% Savings for fees paid in full, with cash or certified check at the time of appointment for treatment of \$1,000 - \$5,000.
 - 10% Savings for fees paid in full, with cash or certified check at the time of appointment for treatment over \$5,000.
- 4. Dental Insurance:** Our office accepts Delta Dental and Blue Cross Dental. For other insurances, payment is due at time of treatment. We will gladly process your claim for your reimbursement.

Appointments

Your appointment time has been reserved just for you. If you cannot keep your appointment, we ask you to give us 48 hours notice so that we will be able to fill your time slot. Otherwise, our office policy is to charge an hourly rate that covers our overhead. Exceptions are occasionally made, but are less likely the less notice we are given or the more often appointments are missed.

Privacy Notice

The privacy of your health and dental information is important to us. Under separate cover, you will receive a copy of our Notice of Privacy Practices. This form describes how your health information may be used and disclosed and how you can get access to this information.

Photography

Dr. Ward often take photographs to better explain certain aspects of your existing dental health or planned treatment to you. We request your permission to show these photographs to better explain treatment options to other patients (as you will be shown photos for the same reason.) And since he has a reputation as an expert on Cosmetic Dentistry, he also makes presentations to other dentists where the photos are invaluable in explaining the latest techniques and the results that can be achieved when done precisely.

Thank you for giving us the opportunity to help you achieve your dental goals. Our staff will strive to deliver the type of service and atmosphere that you should expect from a superb dental office. We value your opinion and appreciate hearing about the things you like and about the things we could improve to better serve you.