



HARTLAND SMILEMAKERS™

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Thank you for allowing us to be part of your health team. In order for us to better work with you and meet your needs, there are a few things we need to know. PLEASE PRINT.

Patient's Full Name _____ What do you prefer to be called? _____

Birthdate _____ Social Security No. _____

Phone No. _____ Cell No. _____ Email _____

Home Address _____ City _____ Zip _____ Fax No. _____

Employer _____ Work Phone No. _____

Address _____ Hourly _____ Salaried _____

Patients Dental Insurance _____ Group No. _____

Address of Insurance _____ Insurance Phone No. _____

Spouse's Name _____ Social Security No. _____ Birthdate _____

Employer & Phone No. _____

Name of Spouse's Dental Insurance (if different) _____ Group No. _____

Address of Insurance _____ Insurance Phone No. _____

If referred, whom may we thank for recommending us? _____

MEDICAL HISTORY

Medical doctor's name, address _____

Are you under a doctor's care now? Why? _____ YES NO

Have you been hospitalized during the past two years? Why? _____ YES NO

Are you taking any medications, pills, or drugs? What? _____ YES NO

Are you allergic to any medication, metals or materials? What? _____ YES NO

Are you pregnant? (women) _____ YES NO

Please **CIRCLE** if you have 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. | Blood Transfusion |
| Rheumatic Fever | Stroke | Emphysema | Chemotherapy/Radiation | Hemophilia |
| Congenital Heart Lesion | Diabetes | Frequent Cough | Arthritis/Gout | AIDS |
| Artificial Heart Valve | Excessive Thirst | Lung Disease | Rheumatism | Venereal Disease |
| Heart Pacemaker | Artificial Joints/Hips | Tuberculosis | Pain in Jaw Joints | Cold Sores |
| Heart Surgery | Kidney Trouble | Liver Disease | Cortisone Medicine | Fever Blisters |
| Blood Disease | Ulcers | Hepatitis A (infect.) | Glaucoma | Herpes |
| Anemia | Allergies | Hepatitis B (serum) | Epilepsy or Seizures | Bruise Easily |
| | | Yellow Jaundice | Nervousness | Sickle Cell Anemia |

None of the above

Have you ever had any other serious illness not circled above? Please describe in detail _____

FINANCIAL INFORMATION

Our office policy requires that your obligation (or ESTIMATED insurance copayment) be paid by the time treatment is completed. Please advise our receptionist if other arrangements are necessary, BEFORE SEEING THE DOCTOR. We will be happy to help you ESTIMATE your copayment based upon our previous experience of what a particular Insurance Company has paid in the past. WE CANNOT GUARANTEE THAT YOUR DENTAL PLAN WILL PAY ANY OR ALL OF YOUR BALANCE. In all cases, balances remaining after insurance has paid will be billed to you. We accept cash, personal checks on local banks, money orders, VISA, Master Card and Discover.

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE ABOVE NAMED DENTIST BY MY INSURANCE CARRIER FOR SERVICES RENDERED.

I AUTHORIZE EITHER OF THE DENTISTS TO RELEASE ANY INFORMATION NECESSARY TO PROCESS CLAIMS.

I AGREE TO BE RESPONSIBLE FOR ANY CHARGES NOT PAID BY MY DENTAL PLAN.

Signature _____ Date _____

-OVER- PLEASE CONTINUE ON BACK!

DENTAL HISTORY

Are you having any pain or discomfort? Please explain. _____

Do you have any questions or concerns about your health? _____

When was your last dental visit, what was done? _____

What was your reason for leaving your former dentist? _____

Are you nervous about seeing the dentist? _____

Have you ever been shown how to brush, floss, clean teeth, gum & tongue? _____

Are you interested in using nitrous oxide _____ or head phones _____ during treatment?

PRE CLINICAL INTERVIEW

1. What can I do for you today? _____

2. How often do you go to the dentist? _____

3. Have you lost any permanent teeth? _____ Why? _____ How long ago? _____

4. Have missing teeth been replaced? _____ Fixed bridge? _____ Removable bridge? _____ Denture? _____

5. Were replacements discussed? _____ Have you ever wondered about replacements? _____

6. How often do you brush your teeth? _____ p.m. _____

7. Do you brush before or after breakfast? _____ If before, why? _____

8. Do you use dental floss? _____

9. Do your gums ever bleed? _____ When? _____

10. Do your gums ever feel irritated, tender or swollen? _____

11. Does food get caught between your teeth when you chew? _____ Where? _____

12. Do you ever have an unpleasant taste in your mouth that you feel might be coming from your teeth or gums? _____

13. Do you smoke? _____ How much? _____

14. Are you aware of any areas of swelling or irritation in or around your mouth? _____

Where? _____

15. Do you have pain in any of your teeth because of heat? _____ Cold? _____ Sweets? _____ Or pressure? _____

Where? _____

16. Can you chew evenly on both sides of your mouth? _____ Do you favor one side? _____

17. In your opinion, what is the overall condition of your teeth? _____ Gums? _____

18. What have other dentists told you about your teeth and gums? _____

19. Are you pleased with the appearance of your teeth? _____ Would you like whiter teeth? _____

20. Did your parents lose their teeth? _____ Why? _____

21. Do you or any member of your family have a problem with snoring? _____

22. What do you expect from your dentist? _____

THANK YOU for filling out this form. If you should ever have any questions, please feel free to ask any of our health team members.