Welcome to Goetz Dental! Please take a few minutes to answer the following questions below so we may better assist you with your health care needs.

GOETZ FAMILY DENTAL

PATIENT INFORMATION

Date : ____________________ Soc. Sec. # : ______________________ Birth date : _____________

Last Name : _________________ First Name : _______________________ Initial : ______________

Address : ______________________________ Cell : ______________ Home Phone: ____________

City : ____ State : ________________ Zip : _________

Sex : ☐ M ☐ F

☐ Minor ☐ Single ☐ Married ☐ Long Term Partner ☐ Divorced ☐ Widowed ☐ Separated

Employer : ____ Business Phone : ______________

Business Address : ______________________________________ Occupation : _________________

Who should we thank for referring you? ____

In case of emergency, who should we contact? ___________________________ Phone : __________

PRIMARY INSURANCE

Person Responsible for Account:

Last Name: _________________ First Name: _________________________ Initial: ______________

Relationship to Patient: _________________ Birth date : ____________ Soc. Sec # : _____________

Address: _______________________________ Cell: ______________ Home Phone: ____________

City: ____ State : ________________ Zip : _________

Responsible Party Employed By: _____________________________ Business Phone : ____________

Business Address: ___________________________________ Occupation: ____________________

Insurance Company: ____

Insurance Company Address: ____

Subscriber I.D.#: ____________________________________ Group #: ________________________

ADDITIONAL INSURANCE

Insured Name:

Last Name : _________________ First Name : _______________________ Initial : ______________

Relationship to Patient : _________________ Birth date : ____________ Soc. Sec # : _____________

Address: ____ Home Phone: ____________

City: ____ State: ________________ Zip : __________

Insured Employed By : ______________________________________ Business Phone : ___________

Insurance Company : ____

Insurance Company Address : ____

Subscriber I.D.#: ____________________________________ Group #: ________________________

HEALTH HISTORY

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs.

Name: ____ Birth date : __________________ Age : ______

Why are you now seeking dental treatment? ____

Please answer each question. Check YES or NO. If in doubt, leave blank

		Yes	No
1.	Are you in good health now?	☐	☐
2.	Are you now under the care of physician?	☐	☐
	If so, what is the condition being treated? ____________________________		
3.	Have you ever been hospitalized or had a serious illness?	☐	☐
	If yes, explain ____________________________		
4.	Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal now than previously?	☐	☐
5.	(Woman) Are you pregnant? If so, give due date ____________________________	☐	☐
6.	Do you use tobacco in any form? If yes, how much ____________________________	☐	☐
7.	Do you use alcoholic beverages (more than 2 drinks per day) ?	☐	☐

8. Do you have or have you ever had any of the following?

GENERAL

	YES	NO
Tire easily, weakness	☐	☐
Marked weight change	☐	☐
Night sweats	☐	☐
Persistent fever	☐	☐
SKIN		
Eruptions (rash) hives	☐	☐
Change color skin color	☐	☐
EYES		
Visual change	☐	☐
Glaucoma	☐	☐
EARS		
Loss of hearing	☐	☐
Ringing in ears	☐	☐
NOSE		
Frequent nosebleeds	☐	☐
Sinus problems	☐	☐
THROAT		
Soreness/hoarseness	☐	☐
NERVOUS SYSTEM		
Stroke	☐	☐
Headaches	☐	☐
Convulsions / epilepsy	☐	☐
Numbness / tingling	☐	☐
Dizziness / fainting	☐	☐
Psychiatric treatment	☐	☐
RESPIRATORY		
Tuberculosis	☐	☐
Emphysema	☐	☐
Asthma / hay fever	☐	☐
Persistent cough	☐	☐
Sputum production (phlegm)	☐	☐
Cough up bloody sputum	☐	☐
Difficulty breathing while lying down	☐	☐
ENDOCRINE		
Diabetes	☐	☐
Family history of diabetes	☐	☐
Thyroid condition/goiter	☐	☐
Other	☐	☐

HEART/BLOOD VESSELS

	YES	NO
Rheumatic fever	☐	☐
Heart murmur	☐	☐
Chest pain/discomfort	☐	☐
Heart attack/trouble	☐	☐
Shortness of breath	☐	☐
Swelling of ankles	☐	☐
High Blood pressure	☐	☐
Congenital heart disease	☐	☐
Mitral valve prolapsed	☐	☐
Artificial heart valve	☐	☐
Pacemaker	☐	☐
Heart surgery	☐	☐
Other	☐	☐
BONE/MUSCLES		
Arthritis/rheumatism	☐	☐
Artificial joints/limbs	☐	☐
DIGESTIVE SYSTEM		
Hepatitis	☐	☐
Jaundice	☐	☐
Ulcers	☐	☐
Change in appetite	☐	☐
Black, bloody or pale stools	☐	☐
UNIRARY		
Kidney disease	☐	☐
Increase in frequency of urination (night)	☐	☐
Burning on urination	☐	☐
Urethral discharge	☐	☐
Bloody urine	☐	☐
Venereal disease	☐	☐
BLOOD		
Bruise easily	☐	☐
Anemia	☐	☐
Blood transfusion	☐	☐
OTHER		
Radiation therapy	☐	☐
Chemotherapy	☐	☐
Tumors or growths	☐	☐
Cancer	☐	☐
HIV+	☐	☐
AIDS	☐	☐

Please complete reverse side

9. Are you ALLERGIC or have you experienced any reaction to the following?

	YES	NO		YES	NO
Local anesthetics (e.g. novocaine)...........................	☐	☐	Aspirin or codeine	☐	☐
Barbiturates/sedatives/sleeping pills	☐	☐	Sulfa drugs	☐	☐
Penicillin/other antibiotics	☐	☐	Other allergies _____________________________________		

10. Are you taking any of the following?

	YES	NO		YES	NO
Antibiotics/sulfa drugs	☐	☐	Tranquilizers	☐	☐
Blood thinners	☐	☐	Insulin/other diabetes drugs	☐	☐
Blood pressure medication	☐	☐	Recreational drugs	☐	☐
Thyroid medicine	☐	☐	Digitalis/others heart medications	☐	☐
Cortisone/steroids	☐	☐	Nitroglycerin	☐	☐
Antihistamines/allergy drugs/cold remedies	☐	☐	Aspirin	☐	☐
			Other medication ___________________________________		

If yes to any of the above, list ***name*** of medication and ***dosage*** below:

1. ____
2. ____
3. ____
4. ____

11. Is there any disease, condition or problem not listed that you think we should know about, or is there any activity your doctor says you cannot do? If so, explain ____
____

12. Physician's Name ____ Phone ________________
13. Have you ever had any serious trouble associated with previous dental treatment? ________________________________
____

14. Does dental treatment make you nervous? No _________Slightly_________Moderately_________Extremely___________
15. Date of last dental visit ____
16. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? ________________________
If so, when? ____
17. Do you have or have you ever had any of the following?

MOUTH	YES	NO	TEETH	YES	NO
Bleeding, sore gums	☐	☐	Loose teeth	☐	☐
Unpleasant taste/bad breath	☐	☐	Sensitive to hot	☐	☐
Burning tongue/lips	☐	☐	Sensitive to cold	☐	☐
Frequent blisters, lips/mouth	☐	☐	Sensitive to sweets	☐	☐
Swelling/lumps in mouth	☐	☐	Sensitive to biting	☐	☐
Ortho treatment (braces)	☐	☐	Food impaction	☐	☐
Biting cheeks/lips	☐	☐	Clenching/grinding	☐	☐
Clicking/popping jaws	☐	☐	Shifting of teeth	☐	☐
Difficulty opening or closing jaw	☐	☐	Change in bite	☐	☐

ORAL HYGIENE

Do you use the following?

	YES	NO
Brush	☐	☐
Dental floss	☐	☐
Fluoride rinse	☐	☐
Other ____		

How often do you brush ________________________

Brush is: Soft☐ Medium☐ Hard ☐

To the best of my knowledge, all of the preceding answers are true and correct.

If I ever any change in my health or change in my medication, I will inform the dentist at the next appointment.

Signature of Patient
Parent or Guardian _________________________________ Date ________________________

FINANCIAL POLICY

This statement is to inform you of our financial policy. We are committed to providing you with the highest quality dental care using only the best materials and technology available. We are also committed to providing you with up-to-date information and educational tool so that we may assist you in maintaining optimum oral health. Our financial policy is intended to facilitate excellent service to you while minimizing our administrative costs.

Payment is expected at the time of service. If you have dental insurance your estimated co-pay is also expected. We accept cash, personal checks and all major credit cards. Outside financing is available through Care Credit and Capital One upon request and approval.

If your account is turned over to our **collection agency** then **you** will be responsible for all **collection costs**. Additionally, our office charges for **broken** and **cancelled** appointments without 48 hour advanced notice.

_________________________ ______________________ _______________

Print Name Signature Date

ASSIGNMENT OF BENEFITS

All charges you incur are **your responsibility** regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with **you**, our patient, not your insurance company. If your dental insurance denies a claim, the balance is **your responsibility**. As a courtesy to you we will help you process all insurance claims. You may direct your insurance company to pay your benefits directly to our office by signing the authorization below.

I have read and understand the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to Goetz Family Dental.

_________________________ ______________________________ _______________

Print Name Signature of Patient or Responsible Party Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been made aware that there is a copy of the office's Notice of Privacy Practices for my review.
____initial

GOETZ FAMILY DENTAL

Sean H. Goetz, DDS

I hereby authorize the release of my dental records to:

Goetz Family Dental

Sean H. Goetz, DDS

670 Boston Post Rd.

Old Saybrook, CT 06475

goetzfamilydental@gmail.com

NAME______________________________

ADDRESS______________________________

____

DOB______________________________

SIGNATURE______________________________

DATE______________________________