Robb HeinricH DDS
Restorative &
Aesthetic Dentistry

Welcome To Our Dental Practice

www.heinrichdds.com
10121 N. Nevada Street, Suite 302 • Spokane, WA 99218 • (509) 467-1117

Date _____

Please answer all questions on **both** sides, so that we may diagnose your oral health as accurately as possible. All information will be kept strictly confidential. Thank You.

Whom may we thank for referring you? _____

PATIENT'S NAME _____ Preferred Name _____

❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed

❑ Male ❑ Female Social Security No. ___ - ___ - ____ Birthdate ___/___/___

Mailing Address _____ Home Phone ( ) -

City _____ State _____ Zip Code _____

Cell ( ) - Fax ( ) - Email _____

Name of Spouse _____ Birthdate ___/___/___ Social Security No. ___ - ___ - ____

Patient Occupation _____ Employer _____ Work Phone ( ) -

Spouse Occupation _____ Employer _____ Work Phone ( ) -

How would you prefer to be contacted to confirm appointments?
Email, Text, Phone Call or a Combination? Please list: _____

PRIMARY DENTAL INSURANCE	SECONDARY DENTAL INSURANCE
Employee _____	Employee _____
Employer _____	Employer _____
Insurance Co. _____ Group# _____	Insurance Co. _____ Group# _____
Employee's S.S. No. ___ - ___ - ____	Employee's S.S. No. ___ - ___ - ____

Person responsible for payment: _____

* * * * * *

IN CASE OF EMERGENCY, WHOM MAY WE CONTACT?

Name _____ Home Ph. No. ( ) - Work Ph. No. ( ) -

Relationship to Patient _____

Payment is due in full at time of treatment, unless prior arrangements have been approved. If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all cost of dental treatment. I hereby authorize release of any information, including the diagnoses and records of treatment to my insurance company.

_____ _____
Signature Date

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HEALTH HISTORY

Chief dental concern: _____

_____

Are you nervous about having dental treatment? ❑ Yes ❑ No

Do you smoke or use tobacco in any form? ❑ Yes ❑ No

Have you been hospitalized in the past 2 years? ❑ Yes ❑ No

Have you been under the care of a medical doctor during the past 2 years? ❑ Yes ❑ No

Physician Name _____

Date of last visit: _____ Phone: _____

Are you currently taking any medications / drugs? ❑ Yes ❑ No

If yes, please list: _____

List Medications: _____

_____

_____

_____

Please list over the counter herbs & supplements:

_____

_____

Please check "Yes or No" to the following conditions:

Y	N		Y	N		Y	N		Y	N	
❑	❑	Stroke	❑	❑	Sickle Cell Disease	❑	❑	Emphysema / Asthma	❑	❑	Fever Blisters / Cold Sores
❑	❑	Heart Disease / Attack / Surgery	❑	❑	Hemophilia	❑	❑	Cough / Tuberculosis (TB)	❑	❑	Fainting / Dizzy Spells
❑	❑	High / Low Blood Pressure	❑	❑	Liver Disease / Yellow Jaundice	❑	❑	Arthritis / Rheumatism	❑	❑	Epilepsy / Seizures
❑	❑	Congenital Heart Defect	❑	❑	Kidney Failure/Disfunction	❑	❑	Venereal Disease	❑	❑	Hay Fever / Sinus Trouble
❑	❑	Heart Murmur / Rheumatic Fever	❑	❑	Thyroid Disease	❑	❑	A.I.D.S. / H.I.V.	❑	❑	Shingles
❑	❑	Heart Pacemaker	❑	❑	Ulcers	❑	❑	Hepatitis: A B C **(circle one)**	❑	❑	Psychiatric Treatment
❑	❑	Artificial Heart Valve	❑	❑	Glaucoma	❑	❑	Frequent Headaches	❑	❑	Drug / Alcohol Addiction
❑	❑	Diabetes	❑	❑	Chemotherapy / Cancer	❑	❑	Artificial Joints (Hip, Knee)			
❑	❑	Blood Transfusion / Anemia	❑	❑	Cosmetic Surgery	❑	❑	Scarlet Fever			

Have you been diagnosed with sleep apnea? ❑ Yes ❑ No **Do you use a CPAP machine to sleep**? ❑ Yes ❑ No

Women: Are you pregnant? ❑ Yes ❑ No Are you nursing? ❑ Yes ❑ No Are you taking birth control? ❑ Yes ❑ No

Please list any serious medical condition(s) that you have/had: _____

_____

Are you allergic to or have you reacted adversely to the following?

❑ Erythromycin	❑ Codeine/other Narcotics	❑ Iodine	❑ Latex
❑ Penicillin	❑ Metals/Jewelry	❑ Aspirin	❑ Sulfa Drugs
❑ Other Antibiotics:	❑ Sulfites/Preservatives		

_____

Medical History Update (For Office Use Only)

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 also give permission to Dr. Robb Heinrich and his staff to use any photos taken for lecturing and continuing education purposes.

I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

_____ _____

Signature Date

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Dental History

Date of last dental exam/cleaning and x-rays _____

Name of previous dentist _____

Reason for leaving _____

Check yes or no if you have had any of the symptoms listed below

Y N

❑ ❑ Are you having any discomfort at this time? _____

❑ ❑ Sensitive teeth _____

❑ ❑ Bleeding gums _____

❑ ❑ Clicking or popping jaw, pain, TMJ, TMD _____

❑ ❑ Dry mouth _____

❑ ❑ Do you clench or grind your teeth _____

❑ ❑ Have you ever had any serious or difficult problems associated with any previous dental treatment?

If yes, please explain_____

❑ Other_____

How many times each day do you brush your teeth?____ How many times each week do you floss? ____

Do you use an electric tooth brush?_____ If yes, which one?_____

Periodontal History

Y N Don't Know

❑ ❑ ❑ Have you ever been told you have periodontal disease?

❑ ❑ ❑ Has anyone in your family had/have periodontal disease?

❑ ❑ ❑ Have you ever had periodontal surgery?

How would you rate your dental health on a scale of 1 (poor) to 10 (excellent) _____

How would you rate your overall health on a scale 1 (poor) to 10 (excellent) _____

Are you happy with the appearance of your smile? Y N Would you like whiter teeth? Y N

Have you whitened your teeth previously? Y N Are you interested in discussing cosmetic dentistry with us? Y N

What is most important to you about your dentist?_____

_____

What is most important to you about your dental office/team?_____

_____

Is there anything else you would like us to know about your previous dental experiences?_____

_____

_____

Is there anything we can do to make your dental visits easier for you?_____

_____

Do you struggle to have a good night sleep, or know you have Sleep Apnea?

_____