Welcome to The Masters Dental Group

TODAY WE WILL TAKE THE FIRST STEP TOWARD A COMPREHENSIVE EXAMINATION AND DIAGNOSIS OF YOUR MOUTH. ACCURATE ANSWERS TO THE FOLLOWING QUESTIONS WILL HELP US, HELP YOU.

Lisa B. Masters, DDS, MS W. Bradley Woods, DDS Victoria A. Vickers, DDS

Patient Information

Patient Name:_____Date of Initial Appointment:_____
_____Male_____Female _____Married_____Single_____Widowed_____Divorced____Child
Street Address:_____Apartment #_____
City:_____State:_____Zip Code:_____
Social Security Number:_____Date of Birth:_____Age:_____
Phone: Mobile:_____Work:_____Home:_____
Email:_____
Name of Emergency Contact Person:_____Phone:_____
Preferred Appointment Times:_____Morning_____Afternoon ____M____T____W_____Th_____F

Employment Information

The following is for: The Patient_____ The Person Responsible for Payment_____
Employer's Name:_____Occupation:_____
Business Address:_____

Referral Information

Whom may we thank for sending you to our office?_____
Friend or Relative?_____Another Patient?_____
Referral from another dental or medical office?_____
Internet or Social Media?_____Other?_____

Dental Information

Reason for Today's appointment?_____
Do you have a General Dentist?_____Date of Last Cleaning_____
Have you had complications, or a bad experience associated with previous dental treatment?_____Yes_____No
If yes, please explain:_____
Do you have any old fillings or other dental work that you do not like?_____
How often do you use the following?_____Toothbrush_____Dental Floss_____Toothpicks_____Water Pick
Do you drink coffee or tea with sugar?_____Do you drink soda or sports drinks with sugar?_____
Do you use breath mints, chewing gum, cough drops, or hard candy?_____

Periodontal Information

Pain in Teeth or Gums	Yes	No	Clench or Grind Teeth at Night	Yes	No
Bleeding Gums While Brushing	Yes	No	Spaces Between Teeth Getting Bigger	Yes	No
Abscess or Gum Swelling	Yes	No	Any Teeth That Feel Loose	Yes	No
Bad Taste in Mouth	Yes	No	Unsatisfactory Chewing	Yes	No
Teeth Sensitive to Hot or Cold	Yes	No	Calculus Forms Rapidly on Teeth	Yes	No

Implant/Prosthetic Information

Do you have any missing teeth that you would like to replace with dental implants?_____
Do you wear a removable dental appliance?_____Do you chew well with the appliance?_____
How many years have you had the appliance?_____Do you like the way the appliance looks?_____
Are you considering new dentures or a new removable appliance?_____

Health Information

Height:_____ Weight_____

Have you ever had any of the following? Please check all that apply:

___Arthritis – Osteo or Rheumatoid Arthritis
___Artificial Joints – Hip/Knee
___COPD or Emphysema
___Alzheimer's Disease/Dementia
___Blood Thinners
___Excessive Bleeding
___Cancer:_____
___Radiation Treatment
___Chemotherapy
___Diabetes – Blood Sugar_____
___AbA1c_____
___Epilepsy/Seizures
___Glaucoma
___Heart Disease
___Heart Valve Replacement
___Pacemaker or Defibrillator
___Arrhythmia
___High or Low Blood Pressure
___HIV or AIDS
___Kidney Disease
___Liver Disease
___Hepatitis A/B/C
___General Anxiety
___Depression
___Bipolar Disorder
___Schizophrenia
___ADHD
___Eating Disorder
___Pregnancy
Due Date:_____
___Rheumatic Fever
___Acid Reflux
___Stroke/TIA
___Urinary Problems
___Increased Frequency of Urination
___Thyroid Problems
___Sleep Apnea
___Use of a C-PAP or E-PAP
___Persistent Cough
___Difficulty Swallowing

ALLERGIES:

___Codeine
___Penicillin
___Latex
___Tape or Adhesive
___Metal Allergies (Costume Jewelry)
___Food Allergies
___Seasonal Allergies

OTHER HEALTH PROBLEMS:

_____
_____
_____

Medications

List all medications and supplements (prescription and over the counter):_____
_____
_____
_____

Name of Physician or Medical Office:_____Telephone Number:_____
Have you been admitted to the hospital or needed emergency medical care during the past 2 years?___Yes__No
If yes, please explain:_____

Social History

Do you smoke or vape?_____How much?_____How many years?_____
Recreational or Medical Marijuana Use?_____Smoke or Edible?_____
How many alcoholic beverages do you have each day?_____Week?_____

Consent for Services

To the best of my knowledge, all the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail. I understand that payment is due at the time service is rendered unless other financial arrangements have been made with the office. I understand that late charges will be added to any unpaid balance due at a rate of 18% per annum. Patients who carry dental insurance understand that all dental services performed are charged directly to the patient, and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms, or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. I have read the above conditions of treatment and payment, and I agree to their content.

Signature:_____Date:_____

Printed Name:_____Signature of parent or Guardian:_____