Nicholas Dose, DMD

601 1st Avenue, Suite A | Lake Oswego, OR 97034
Phone (503) 636-2525

Patient:_____ **Entry Date:** _____

Patient/Responsible Party

Patient information

Name (Last, First, Middle) _____ Preferred name _____ Birthdate _____

Address _____ Home phone _____

City _____ State _____ Zip _____ SSN _____ Cell phone _____

Occupation _____ Email _____ Work phone _____

How do you prefer to receive appointment reminders?
○ Email ○ Text ○ Phone

Whom may we thank for referrring you? _____

Name of nearest relative or friend not living with you _____ Phone # _____

Address _____ Relationship _____

Responsible party

Name _____ ☐ Self ☐ Father ☐ Mother ☐ Spouse ☐ Other

Address _____ Phone _____

Previous dentist _____ Office phone# _____ City, State _____ How long? _____

Your physician _____ Physician's phone# _____

Please check how you wish to arrange for payment

☐ I will pay for the entire fee at the time of treatment.
☐ I would prefer 50% down and the remainder in 3 monthly payments.
☐ I wiould like to use my VISA or Mastercard.
☐ I have dental insurance, but I realize I am still responsible for the entire amount.

Primary Dental Insurance

Pri. Sub. name _____ Pri .Sub. date of birth _____ Pri. Sub. ID# _____

Pri. Ins Co name _____ Pri.Ins Co address _____

Pri. Policy/Group# _____ Who is covered? ☐ Employee ☐ Spouse ☐ Child

Secondary Dental Insurance

Sec. Sub. name _____ Sec.Sub. date of birth _____ Sec. Sub. ID# _____

Sec. Ins Co name _____ Sec.Ins Co address _____

Sec. Policy/Group# _____ Who is covered? ☐ Employee ☐ Spouse ☐ Child

Authorization

I hereby authorize payment to Nicholas Dose, DMD, PC of the group insurance benefits otherwise payable to me. I hereby authorize the doctor to release information necessary to secure the payments of benefits. I understand that I am responsible for all costs of dental treatment. I hereby authorize Dr. Nicholas Dose to administer such medications and therapeutic procedures as may be necessary for proper dental care. The information on this form and the medical history form are correct to the best of my knowledge. I give permission to perform necessary dental work.

Signature of responsible party

X _____

_____

Signer's Full Name Date

Dental History

Periodontal disease is caused by a combination of complex factors and the following questions are designed to help us identify them. The success of treatment is dependent upon this. Therefore, although some of the following questions may seem unrelated to your periodontal condition, they are all associated with proper management of your oral health. Answers to these questions are for our records and will be considered confidential.

Please describe fully any YES answers.
Use the box at the bottom of the next page if needed.

(DK means don't know)

	Yes	*No*	*DK*
Do you presently have any dental pain or discomfort?	☐	☐	☐
Please describe: _____ How long? _____			
Do your gums bleed?	☐	☐	☐
Where? _____ When? _____			
Are you conscious of bad taste or bad breath?	☐	☐	☐
Do you have any pain or soreness in your gums?	☐	☐	☐
Does food wedge between your teeth and cause gum irritation?	☐	☐	☐
Do tartar and stain return quickly?	☐	☐	☐
Are your teeth painful to heat, cold, or sweets?	☐	☐	☐
Which sensitivities? _____			
Are you conscious of any loose teeth?	☐	☐	☐
Have you noticed your teeth drifting, separating, or crowding?	☐	☐	☐
Do you have problems chewing?	☐	☐	☐
Have you noticed your bite changing?	☐	☐	☐
Do you have any difficulty (pain, clicking, popping, etc) in the jaw joints?	☐	☐	☐
Do cavities develop quickly?	☐	☐	☐
Date of last visit to the dentist _____ What was done? _____			
Last cleaning _____ Frequency of cleanings? _____			
How often have you visited the dentist in the past? _____			
Do you feel anxiety when seeing a dentist?	☐	☐	☐
Have you had difficulty following a dental extraction or other treatment (bleeding or infection)?	☐	☐	☐
If yes, please explain: _____			

Dental History continued

Please describe fully any YES answers.
Use the box at the bottom of the page if needed.

(DK means don't know)

	Yes	*No*	*DK*
Have you had previous periodontal treatment for gum disease?	☐	☐	☐
Where, when and by whom? _____			
Is there a history of gum disease in your family?	☐	☐	☐
Is there a history of diabetes in your family?	☐	☐	☐
Is there a history of heart disease in your family?	☐	☐	☐
Have you had previous orthodontic treatment (braces)?	☐	☐	☐
Are you missing any teeth?	☐	☐	☐
When lost? _____ Why? _____			
Are there any missing teeth which have not been replaced?	☐	☐	☐
Why Not? _____			
Have you ever had surgery or x-ray treatment for a tumor, growth or other condition of your head, mouth or lips?	☐	☐	☐
Do you ordinarily place foreign object between your teeth? (pens, pencils, pipe, fingernails, etc)	☐	☐	☐
Do you have a habit of biting our lip, tongue, or cheek?	☐	☐	☐
Do you clench or grind your teeth during the day or night?	☐	☐	☐
Are you conscious of any habit with your tongue (thrusting, etc)?	☐	☐	☐

I use a: ☐ Hard toothbrush ☐ Medium toothbrush ☐ Soft toothbrush ☐ Electric toothbrush

How often do you use: Floss? _____ Toothpicks? _____

Mouth rinses? _____ Other? _____

Have you ever had instructions on how to clean your teeth?	☐	☐	☐
By whom? _____			
Are you unhappy with the way your teeth look?	☐	☐	☐
Describe why? _____			

How would you feel if you were to lose your teeth? _____

What is your estimate of the health of your gums? ☐ Good gum health ☐ Fair gum health ☐ Poor gum health

Additional information