Dr. Gary Wessels, Inc.

Comprehensive and Implant Dentistry

Welcome to our office.

Thank you for trusting us with your dental care. Please read and initial in **two** locations below.

What we Believe in

Our Mission is to provide you with excellent quality service and care, with a focus on reducing your risks of dental problems over the long term.

Payment Responsibility.

You are ultimately responsible for payment for all services provided to you.

If you have a dental plan, we will bill your plan on your behalf. If a co-pay or deductible applies, this amount is due at the time of treatment.

Sometimes insurance payments vary from estimates. Any amounts remaining unpaid by your plan after 45 days will be billed to you.

It is your responsibility to track your coverage and be aware of any limits that may apply to your treatment. If you have questions regarding your coverage, we will be happy to assist you.

✔ Please initial here: _____.

Appointments

-When you book an appointment, we reserve time specifically for you.

-We plan for specific treatment steps for each appointment you book with us.

-If you need to make changes, or if you have any questions about your upcoming appointment, please **contact us at least 2 open business days before your appointment** so we can arrange your care to best meet your needs. We are open Monday to Thursday.

-We will send an appointment reminder by phone, e-mail, and / or text message 1-3 days prior to your appointment.

✔Please initial here: _____.

Welcome to our office! We look forward to serving you.

We collect personal, dental, and medical information to ensure your safety while under our care and to facilitate the highest quality of care for you.

Personal Information

Name _____ Nickname _____

☐Male ☐Female ☐Adult ☐Child Spouse's Name _____

If Child, Name of Parent(s) or Guardian_____

Address _____ City _____ Postal Code _____

Phone: ☐ Home _____ ☐ Work _____ ☐ Cell _____

☐ E-mail _____ Date of birth (m) _____(d) _____(y) _____

(Please place a check mark next to your preferred mode of contact)

How did you hear of our office? _____

Primary Dental Insurance	Secondary Dental Insurance
Name of Insured_____ M☐ F☐	Name of Insured_____ M☐ F☐
Insurance Co_____	Insurance Co_____
Employer_____	Employer_____
Insured D.O.B. (m)_____(d)_____(yr)_____	Insured D.O.B. (m)_____(d)_____(yr)_____
Group / Policy #_____	Group / Policy #_____
I.D. # / Cert_____	I.D. # / Cert_____

Name of previous dentist _____ Province / State _____

When was your last dental hygiene appointment? _____

Do you have any food, drug, or environmental allergies? YES ☐ NO ☐
If so, please list: _____

(Women) Is there any possibility that you are pregnant? YES ☐ NO ☐

Medical History

Do you take any medication, supplement, or homeopathic remedy? YES ☐ NO ☐
If so, please list:

_____

_____

_____

Do you have any illnesses or medical conditions? YES ☐ NO ☐
If so, please list: _____

Have you been hospitalized in the last 5 years? YES ☐ NO ☐
If so, for what reason? _____

Are you being treated for a specific illness right now? YES ☐ NO ☐
If so, please list: _____

Have you ever been advised to take antibiotics or "premedication" before dental treatment (due to a pre-existing medical condition)? YES ☐ NO ☐

If so, why? _____

Do you take blood thinners? YES ☐ NO ☐

Do you bruise easily or bleed abnormally? YES ☐ NO ☐

Do you have any artificial joints or valves? YES ☐ NO ☐
If so, where and when were these placed? _____

Have you ever had an unusual reaction to drugs or medicines, YES ☐ NO ☐

including dental freezing?
If so, please list: _____

Have you ever been warned not to take certain medications? YES ☐ NO ☐
If so, please list: _____

Have you, in the last 6 months, taken **prescription** steroids or anti-inflammatories for non-dental problems? YES ☐ NO ☐

Do you experience shortness of breath upon exertion? YES ☐ NO ☐

Have you ever had radiation treatment or chemotherapy? YES ☐ NO ☐
If so, please provide details and areas treated:

_____

Do you have any head, neck, or back injuries, YES ☐ NO ☐

or pain issues? Is so, please describe_____

Are you often exhausted or fatigued? YES ☐ NO ☐

Do you consider yourself a sensitive or touchy person? YES ☐ NO ☐

Are you often unhappy or depressed? YES ☐ NO ☐

Do you smoke or use tobacco in any form? YES ☐ NO ☐

Name of your Physician_____

Date of last medical exam_____

Do you have or have you ever had any of the following? (Check if applicable)

☐ Heart disease /attacks	☐ Diabetes	☐ Osteoporosis / Osteopenia
☐ Heart defects	☐ Bleeding problems	☐ Digestive disorders (eg Gastric Reflux)
☐ Prosthetic heart valve(s)	☐ Ulcers or stomach problems	☐ High Cholesterol
☐ Heart Murmur	☐ Stroke	☐ Hormone Deficiency
☐ High or Low Blood Pressure	☐ Epilepsy / Seizures	☐ Alcohol / Drug Dependency
☐ Anemia	☐ Rheumatic or Scarlet fever	☐ Thyroid / Parathyroid disease
☐ HIV / AIDS	☐ Hepatitis B or C	☐ Kidney disease
☐ Tuberculosis	☐ Liver disease	☐ Herpes /Cold sores
☐ Jaundice	☐ Venereal diseases	☐ Psychiatric care
☐ Artificial joint(s)	☐ autoimmune disease	☐ Snoring
☐ Pacemaker	☐ Asthma	☐ Organ Transplants
☐ Ear / Nose / Throat disorders	☐ Eye disorders	☐ Cancer

If any of the above are circled, please provide details:

_____

Do you have any other disease, condition, or problem not listed? YES ☐ NO ☐

If so, please list: _____

Please advise us of any future changes in your medications or medical history

I, the undersigned, certify that all of the information provided is true to the best of my knowledge, and I have not knowingly omitted any information. I consent to my physician or pharmacist being contacted, if necessary, to obtain information that is required for my dental care. I authorize Dr. Gary Wessels, Inc. to release information necessary to process insurance claims (if any). I consent to e-mail and text message contact from this office. I understand that I may terminate e-mail or text message communication with this office by replying to either with “Unsubscribe”.

Payment is required from you, at the time of service, for your portion of our fees.

Your signature below indicates that you understand and accept this policy.

Signature_____ **Date**_____

DENTAL HISTORY

Name_____ Nickname_____ Age_____
Referred by_____How would you rate the condition of your mouth? ☐Excellent ☐Good ☐Fair ☐Poor
Previous Dentist _____How long have you been a patient?_____Months/Years _____
Date of most recent dental exam _____/_____/_____ Date of most recent x-rays _____/_____/_____
Date of most recent treatment (other than a cleaning) _____/_____/_____
I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: YES NO

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] _____ ☐ ☐
2. Have you had an unfavorable dental experience? _____ ☐ ☐
3. Have you ever had complications from past dental treatment? _____ ☐ ☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____ ☐ ☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____ ☐ ☐
6. Have you had any teeth removed or missing teeth that never developed? _____ ☐ ☐

GUM AND BONE

7. Do your gums bleed or are they painful when brushing or flossing? _____ ☐ ☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ ☐ ☐
9. Have you ever noticed an unpleasant taste or odor in your mouth? _____ ☐ ☐
10. Is there anyone with a history of periodontal disease in your family? _____ ☐ ☐
11. Have you ever experienced gum recession? _____ ☐ ☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____ ☐ ☐
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? _____ ☐ ☐

TOOTH STRUCTURE

14. Have you had any cavities within the past 3 years? _____ ☐ ☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____ ☐ ☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____ ☐ ☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____ ☐ ☐
18. Do you have grooves or notches on your teeth near the gum line? _____ ☐ ☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____ ☐ ☐
20. Do you frequently get food caught between any teeth? _____ ☐ ☐

BITE AND JAW JOINT

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ ☐ ☐
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? _____ ☐ ☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____ ☐ ☐
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____ ☐ ☐
25. Are your teeth becoming more crooked, crowded, or overlapped? _____ ☐ ☐
26. Are your teeth developing spaces or becoming more loose? _____ ☐ ☐
27. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together? _____ ☐ ☐
28. Do you place your tongue between your teeth or close your teeth against your tongue? _____ ☐ ☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ ☐ ☐
30. Do you clench your teeth in the daytime or make them sore? _____ ☐ ☐
31. Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth? _____ ☐ ☐
32. Do you wear or have you ever worn a bite appliance? _____ ☐ ☐

SMILE CHARACTERISTICS

33. Is there anything about the appearance of your teeth that you would like to change? _____ ☐ ☐
34. Have you ever whitened (bleached) your teeth? _____ ☐ ☐
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____ ☐ ☐
36. Have you been disappointed with the appearance of previous dental work? _____ ☐ ☐

Patient's Signature _____ Date_____
Doctor's Signature _____ Date _____

Email Form to Dr Wessels