Welcome to Family Dentistry and Orthodontics, the office of Dr. Wayne Trowell!

Please print and complete this form before your dental appointment to ensure we get you seated on time – You may also e-mail to DrTrowell@Gmail.com.

About You:

Patient Name:____Nickname: _______________________

SS #: ______________________Drivers License #:___________________________ Date of Birth: ___________

Home Address: ____

Mailing Address (if different from home): ____

E-Mail Address: ____

Home Phone: ____________________Cell Phone:______________________Work Phone: _________________

Occupation: ________________________ Employer: ____

What are your hobbies: ____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouses Name: ____________________________________ Do you have children?: ☐ No ☐ Yes

Are any of your friends or family members patients of Dr. Trowell's? ☐ No ☐ Yes, Please list:

____

Whom may we thank for referring you to our practice?: ____

Person Responsible for Account:

Name: ____

Relation to Patient: ____

Billing Address (if different than mailing address): ____

SS #: ______________________Drivers License #:___________________________ Date of Birth: ___________

Home Phone: ____________________Cell Phone:______________________Work Phone: _________________

Payment Method: ☐ Cash ☐ Check

☐ Credit Card (Enter Card #)_____________________________ Exp_______ Zip __________ CVC Code_____

Primary Dental Insurance:

Subscriber to Insurance Policy: ______________________________ Relation to Patient: __________

Subscribers Date of Birth: ____________________ Subscribers SS #: ____________________________

Subscribers Employer: ______________________ Insurance Policy ID #: _______________________

Insurance Company Name: ______________________ Insurance Policy Group Number: ____________

Insurance Company Providers Phone #: _________________ Is your policy a PPO plan? ☐ No ☐ Yes

Insurance Company Claims Mailing Address: ____

____

Is patient a full time student? ☐ No ☐ Yes

If so please advise name of school and status: ____

* Please Note – Our office does not process secondary dental claims or medical insurance claims, however we will provide you with the information needed for you to process directly. *

Dental Information:

Reason for today's visit: ☐ Exam/Establish ☐ Emergency ☐ Consultation

Are you in pain or having discomfort? ☐ Yes ☐ No ☐ Sometimes
If yes or sometimes please indicate area and how long you've been experiencing: ____________________________

Please indicate if you're having any of the following problems:

☐ Discomfort, clicking or popping of jaw ☐ Lost/Broken Filling(s) ☐ Stained Teeth

☐ Sensitive tooth, teeth or gums ☐ Teeth Grinding ☐ Locking Jaw

☐ Blisters/Sores in or around mouth ☐ Broken/Chipped tooth ☐ Ringing in Ears

☐ Red, swollen or bleeding gums ☐ Bad Breath ☐ Other (Please Explain): _________________

Previous Dentist (Name/Phone Number/Email Address):

____

____

Last Dental Exam: _____________________ **Last Dental X-rays**: __________________________

If recent x-rays were taken at a previous office please contact that office and request your x-rays be e-mailed to our office

Are you fearful of dental treatment? ☐ No ☐ Yes. On a scale of 1 (least) to 10 (most) how would you rate your fear?: ___

Have you had an unfavorable dental experience in the past? ☐ No ☐ Yes
If you'd like to share your experience we'd love to hear about it so we can discuss your concerns: ____________________________

Have you ever had complications from past dental treatment? ☐ No ☐ Yes
If you'd like to share your experience we'd love to hear about it so we can discuss your concerns: ____________________________

Have you ever had trouble getting numb or had any reactions to local anesthetic? ☐ No ☐ Yes
If you'd like to share your experience we'd love to hear about it so we can discuss your concerns: ____________________________

Have you ever worn braces, have any sort of orthodontic treatment or have your bite adjusted?
☐ No ☐ Yes – Please explain: ____

Have you had any teeth removed?
☐ No ☐ Yes – Please explain: ____

Is there anything about the appearance of your teeth that you would like to change?
☐ No ☐ Yes – Please explain: ____

Have you ever whitened (bleached) your teeth? ☐ No ☐ Yes

Have you felt uncomfortable or self conscious about the appearance of your teeth? ☐ No ☐ Yes

Have you been disappointed with the appearance of previous dental work?
☐ No ☐ Yes – Please explain: ____

Do you have problems with your jaw joint, such as; pain, sounds, limited opening, locking or popping?
☐ No ☐ Yes – Please explain: ____

Do you have any problems chewing gum or hard foods?
☐ No ☐ Yes – Please explain: ____

Are you aware, or have you been told that you snore? ☐ No ☐ Yes

Do you wake up at night choking or gasping? ☐ No ☐ Yes

Have you ever been tested for sleep apnea? ☐ No ☐ Yes

Are you interested in a mouth piece to help with snoring issues? ☐ No ☐ Yes

Have your teeth changed in the last 5 years, become shorter, thinner or worn?
☐ No ☐ Yes – Please explain: ____

Are your teeth crowding or developing spaces? ☐ No ☐ Yes

Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?
☐ No ☐ Yes – Please explain: ____

Do you clench your teeth in the daytime or make them sore?
☐ No ☐ Yes – Please explain: ____

Do you have any problems with sleep or wake up with an awareness of your teeth?
☐ No ☐ Yes – Please explain: ____

Do you wear or have your ever worn a bite appliance?
☐ No ☐ Yes – Please explain: ____

Have you had any cavities within the past 3 years?
☐ No ☐ Yes – Please explain: ____

Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?
☐ No ☐ Yes – Please explain: ____

Do you feel or notice any holes (Ex. Pitting, Craters) on the biting surface of your teeth?
☐ No ☐ Yes – Please explain: ____

Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?
☐ No ☐ Yes – Please explain: ____

Do you have grooves or notches on your teeth near the gum line?

☐ No ☐ Yes – Please explain: ______________________________

Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?

☐ No ☐ Yes – Please explain: ______________________________

Do you get food caught between any teeth?

☐ No ☐ Yes – Please explain: ______________________________

Do your gums bleed when brushing or flossing?

☐ No ☐ Yes – Please explain: ______________________________

Have you ever been treated for gum disease or been told you have lost bone around your teeth?

☐ No ☐ Yes – Please explain: ______________________________

Have you ever noticed an unpleasant taste or odor in your mouth?

☐ No ☐ Yes – Please explain: ______________________________

Is there anyone with history of periodontal disease in your family?

☐ No ☐ Yes – Please explain: ______________________________

Have you ever experienced gum recession?

☐ No ☐ Yes – Please explain: ______________________________

Have you ever had any teeth become loose on their own (without injury), or do you have difficulty eating an apple?

☐ No ☐ Yes – Please explain: ______________________________

Have you experienced a burning sensation in your mouth?

☐ No ☐ Yes – Please explain: ______________________________

How many times a day do you brush your teeth? ______________________________

How many times a week do you floss? ______________________________

What type of tooth brush do you use?: ☐ Soft Bristle ☐ Medium Bristle ☐ Hard Bristle ☐ Electronic

How would you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

Medical History:

Are you currently taking any of the following medications?:

☐ Nerve Pills ☐ Pain Killers (Including Asprin) ☐ Muscle Relaxers ☐ Stimulants

☐ Blood Thinners ☐ Tranquilizers ☐ Insulin ☐ Meds for Osteoporosis

☐ Blood Pressure Meds c:

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (Use the back of this form if necessary):

Are you allergic to any of the following:

☐ Latex ☐ Penicillin/Amoxicillin ☐ Tetracycline ☐ Aspirin ☐ Dental Anesthetics

☐ Foods: ______________________________ ☐ Other(s):______________________________

Do you require pre-medication? ☐ Yes ☐ No ☐ Don't know

Do you use tobacco? ☐ No ☐ Yes/How used?______________ How much?__________ How long?_________

Please rate your general health from 1-10: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Do you wear contact lenses? ☐ Yes ☐ No

Do you *have* or *have you had* any of the following diseases, medical conditions or procedures?
(Circle Y for Yes OR N for No)

Y N Aids/HIV	**Y N** Allergy/Sinus Issues	**Y N** Alzheimer/Dementia	**Y N** Anemia
Y N Arthritis	**Y N** Artificial Joints	**Y N** Asthma/Respiratory	**Y N** Back/Neck Issues
Y N Cancer (Type)_________	**Y N** Codeine Allergy	**Y N** Diabetes	**Y N** Dizziness/Fainting
Y N Glaucoma	**Y N** Hay Fever	**Y N** Head Injuries	**Y N** Heart Attack/Stroke
Y N Heart Disease	**Y N** Heart Murmur	**Y N** Hepatitis A B or C	**Y N** High / Low Blood Pressure
Y N Hydrocodone Sensitivity	**Y N** Jaundice	**Y N** Kidney Disease	**Y N** Liver Disease
Y N Mental Disorders	**Y N** Nervous	**Y N** Pacemaker	**Y N** Pregnancy
Y N Radiation/Cobalt Treatment	**Y N** Rheumatic Fever	**Y N** Rheumatism	**Y N** Severe/Frequent Headaches
Y N Shingles	**Y N** Thyroid Problems	**Y N** TMJ/Jaw Issues	**Y N** Tuberculosis
Y N Tumors/Growths	**Y N** Ulcers	**Y N** Stds	

Please list any other surgeries or medical conditions you have or ever had:

____

____

For Women:

Are you taking Birth Control pills? ☐ No ☐ Yes

How many children have you had? _______________

Are you pregnant? ☐ No ☐ Yes/What is your due date? _____

Are you nursing? ☐ No ☐ Yes

For Children (under 18 years old):

The following questions are **in addition** the above, so please complete all sections.

Mothers Name: ___________________________________

Fathers Name: ___________________________________

Mothers Home Phone: _____________________________

Fathers Home Phone: _____________________________

Mothers Cell Phone: _______________________________

Fathers Cell Phone: _______________________________

Mothers Work Phone: ______________________________

Fathers Work Phone: ______________________________

Mothers Home Address: ____________________________

Fathers Home Address: ____________________________

Mothers Mailing Address: __________________________

Fathers Mailing Address: __________________________

Mothers E-Mail Address: ___________________________

Fathers E-Mail Address: ___________________________

Mothers Date of Birth: __________ SS#: ______________

Fathers Date of Birth: _____________ SS#: ____________

Mothers Drivers License Number: ____________________

Fathers Drivers License Number: ____________________

Mothers Employer: ____________________________ Fathers Employer: ____________________________

Who has legal custody of the patient? ☐ Mother ☐ Father ☐ Other: ___________________________

Whom do you give permission to accompany patient and make decisions regarding patients treatment at any future dental appointments?

1 - 2 - 3 –

Does your child *have* or has he/she *had* any of the following diseases, medical conditions or procedures that were not previously listed in the medical history section above?

(Circle Y for Yes OR N for No)

Y N Artificial Heart Valves	**Y N** Congenital Heart Defect	**Y N** Scarlet Fever	**Y N** Surgeries/Operations
Y N Hearing Problems	**Y N** Tonsillitis	**Y N** Hemophilia	**Y N** Abnormal Bleeding
Y N Cleft Lip/Palate	**Y N** Birth Defects	**Y N** Hyper Active/ADD	**Y N** Seizures/Epilepsy
Y N Cerebral Palsy	**Y N** Surgeries / Operations	(Please List):	

Has the child ever taken the drug Ritalin? ☐ No ☐ Yes/How Long____________

Does the child do any of the following:

☐ Thumb/Finger Sucking ☐ Tongue Thrusting/Sucking ☐ Heavy Snoring ☐ Mouth Breathing ☐ Lip Sucking/Biting

Is the child's water fluoridated? ☐ No ☐ Yes

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.

- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the practice manager. If account is not paid within 30 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

- Insurance: Our office understands the value of insurance benefits to our patients and will gladly work with you to help get the maximum benefits available to you. If we agree to accept assignment of benefits, you will be required to pay your deductible and your estimated portion of charges not covered by your insurance. Our estimate is based on the basic coverage advised by your insurance company, but just as your insurance will advise there is no guarantee of payment until payment is made. Again, all we can give you is an estimate. We will assist you in dealing with your insurance company, but the ultimate responsibility lies with you. After 30 days the balance will be due in full subject to final approval by your insurance company and could therefore change the amount due to our office. Secondary insurance must be filed by the patient.

- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims on my behalf.

By signing below I state that I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature ____Date ___________________

☐ Adult Patient ☐ Parent or Guardian ☐ Spouse