Olson Family Dental

"Where Your Smile Feels Right at Home"

417.823.4900
1036 W Battlefield
Springfield, MO 65807
www.springfielddentist.net

Please Read Carefully

Welcome to Olson Family Dental! Thank you for choosing to join our family at Olson Family Dental. We work hard to ensure your visit with us is the easiest and most enjoyable experience you've ever had at a dental office. If there is anything we can do to make your visit more comfortable or convenient, please let us know.

Appointment Agreement: We go out of our way to provide extra time for you and the dentist to discuss your dental health and concerns and to discuss treatment plans that work best for you. We ask that you be present for all of your scheduled appointments. We treat any appointment as a bond of trust between you and us that we will be there to serve you, and you will be present for the appointment. Therefore, we do not allow frequent cancellations or changes in appointment times with less than a **48 hour notice**. Appointments canceled with less than a 48 hour notice will be charged a **$50 fee**.

Insurance Made Easy: For your convenience, we will file and submit your insurance claims for you at no additional fee. Please note that **after 60 days, any unpaid or outstanding insurance balance will be due by you**, the patient. While we file claims for you as a service, it is your responsibility to maintain and understand your insurance benefits. All problems with insurance are between the patient and the insurance company.

Financing Options: For those without dental insurance or for more extensive needs we offer financing for those approved. If you are in need of financing options, please discuss your financial needs with the front desk before scheduling treatment. If your treatment plan is over $500, you may be eligible for a 5% courtesy discount. Check with the front desk to see how you can qualify.

Financial Responsibility: You can expect to see monthly statements from Olson Family Dental until your account is paid in full. You will be responsible for your portion of payment plus any unmet deductibles on the day of service. It is important to understand that you, the patient, are responsible for **All** fees incurred from your visit. An account becomes **overdue after 90** days and will be charged a $25 late fee for every month the balance remains unpaid. You are responsible for all fees incurred while collecting unpaid balances.

I have read and understand my financial responsibilities:

_____ _____

Print Name Date

X_____

Signature

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Today's Date___/___/___

PATIENT INFORMATION

Last Name_____ First Name_____ MI_____

Social Security #_____ Male ☐ Female ☐

Birth Date___/___/___ Preferred Name_____

Marital Status Minor ☐ Single ☐ Married ☐ Widowed ☐

Address_____

City_____ State_____ Zip_____

Home Phone_____ Preferred_____

E-mail Address_____

Employer_____ Work Phone_____

Emergency Contact: Name_____ Relationship_____

Phone Number_____

Is there someone we can thank for referring you to our office? Name_____

If not, how did you hear about us?

☐ Website ☐ Google Search ☐ Insurance ☐ Facebook ☐ Sign ☐ Other_____

PERSON RESPONSIBLE FOR THIS ACCOUNT

Last Name_____ First Name_____ MI_____

Home Phone_____ Preferred_____ Employer_____

Social Security #_____ Relationship to Patient_____

Address_____

City_____ State_____ Zip_____

INSURANCE INFORMATION

Policy Holder's Name_____ Social Security #_____

Date of Birth___/___/___ Relationship to Patient_____

Employer_____ Insurance Company_____

Group #_____ Employer/Cert #_____

Have you submitted this insurance to another dental office this year? Yes ☐ No ☐

Please note that the person responsible for this account will be responsible for ALL charges not covered by the insurance company, at the time of service.

Medical History

Patient Name _____ Age _____

Name of Physician _____

Date of most recent physician examination _____ Purpose _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	Yes	No
1. Hospitalization for illness or injury? _____	☐	☐
2. An allergic reaction to:		
Aspirin, Ibuprofen, Acetaminophen, Codeine_	☐	☐
Penicillin _____	☐	☐
Erythromycin _____	☐	☐
Tetracycline _____	☐	☐
Sulfa _____	☐	☐
Local anesthetic _____	☐	☐
Fluoride _____	☐	☐
Metals (nickel, gold, silver, _____) _____	☐	☐
Latex _____	☐	☐
Other (_____) _____	☐	☐
3. Heart Problems or cardiac stent within last 6 mo._	☐	☐
4. History of infective endocarditis _____	☐	☐
5. Artificial heart valve, repaired heart defect _____	☐	☐
6. Rheumatic or scarlet fever _____	☐	☐
7. Artificial prosthesis (heart valve or joints) _____	☐	☐
8. Pacemaker or implantable defibrillator _____	☐	☐
9. High or low blood pressure _____	☐	☐
10. A stroke or taking blood thinners _____	☐	☐
11. Anemia or other blood disorder _____	☐	☐
12. Prolonged bleeding due to slight cut _____	☐	☐
13. Emphysema, sarcoidosis _____	☐	☐
14. Tuberculosis _____	☐	☐
15. Asthma _____	☐	☐
16. Breathing or sleep problems (i.e. snoring, sinus) __	☐	☐
17. Kidney disease _____	☐	☐
18. Liver Disease _____	☐	☐
19. Jaundice _____	☐	☐
20. Thyroid, parathyroid disease, or calcium deficiency	☐	☐
21. Hormone deficiency _____	☐	☐
22. High cholesterol or taking statin drugs _____	☐	☐
23. Diabetes _____	☐	☐
24. Stomach or duodenal ulcer _____	☐	☐
25. Digestive disorders (i.e. gastric reflux) _____	☐	☐
26. Osteoporosis/osteopenia (taking bisphosphonates)	☐	☐
27. Arthritis _____	☐	☐
28. Head or neck injuries _____	☐	☐
29. Epilepsy, convulsions (seizures) _____	☐	☐
30. Neurological problems _____	☐	☐
31. Viral infections and cold sores _____	☐	☐
32. Lumps or swelling in the mouth _____	☐	☐
33. Hives, skin rash, hay fever _____	☐	☐
34. Venereal disease _____	☐	☐
35. Hepatitis (Type _____) _____	☐	☐
36. HIV/AIDs _____	☐	☐
37. Tumor, abnormal growth _____	☐	☐
38. Radiation therapy _____	☐	☐
39. Chemotherapy _____	☐	☐
40. Emotional problems _____	☐	☐
41. Psychiatric treatment _____	☐	☐
42. Antidepressant medication _____	☐	☐
43. Alcohol/street drug use _____	☐	☐
ARE YOU:		
44. Presently being treated for any other illness _____	☐	☐
45. Aware of a change in your health _____	☐	☐
46. Taking medication for weight management _____	☐	☐
47. Taking dietary supplements _____	☐	☐
48. Often exhausted or fatigued _____	☐	☐
49. Experiencing frequent headaches _____	☐	☐
50. A prev/current smoker or use smokeless tobacco __	☐	☐
51. Considered a touchy person _____	☐	☐
52. Often unhappy or depressed. _____	☐	☐
53. FEMALE - Taking birth control pills _____	☐	☐
54. FEMALE - Pregnant _____	☐	☐

Describe any current medical treatment, impending surgeries or other treatment that may possibly affect your dental treatment

_____

List all medications, supplements, and vitamins taken within the last two years:

Drug	Purpose	Drug	Purpose

The medical information provided is the most recent, accurate portrayal of my current medical health.

_____ X _____ _____

Print Name Signature Date

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE TO YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING

FOR DOCTOR'S USE ONLY: Medical history last reviewed on:

Blood Pressure _____ Date _____ Doctor's Signature _____

Blood Pressure _____ Date _____ Doctor's Signature _____

Blood Pressure _____ Date _____ Doctor's Signature _____

DENTAL HISTORY

Name _____

How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist _____ Reason for Leaving _____

Last Dental Exam ___/___/_____ Purpose of Exam _____

I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not Routinely

Do you have any immediate concerns? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY	**YES**	**NO**
1. Are you fearful of dental treatment? On a scale from 1(least) to 10 (most), how fearful? [_____]__	☐	☐
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 have your bite adjusted? _____	☐	☐
SMILE CHARACTERISTICS		
6. Is there anything about the appearance of your teeth that you would like to change? _____	☐	☐
7. Have you ever whitened or bleached your teeth? _____	☐	☐
8. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____	☐	☐
9. Have you been disappointed with the appearance of previous dental work? _____	☐	☐
BITE AND JAW JOINT		
10. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)____	☐	☐
11. Do you have any problems chewing gum? _____	☐	☐
12. Do you have any problems chewing bagels, baguettes, protein bars, or other hard foods? _____	☐	☐
13. Have your teeth changed in the last 5 years, become shorter, thinner, or worn? _____	☐	☐
14. Are your teeth crowding or developing spaces? _____	☐	☐
15. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?____	☐	☐
16. Do you clench your teeth in the daytime or make them sore? _____	☐	☐
17. Do you have any problems with sleep or wake up with an awareness of your teeth? _____	☐	☐
18. Do you wear or have you ever worn a bite appliance? _____	☐	☐
TOOTH STRUCTURE		
19. Have you had any cavities within the past 3 years? _____	☐	☐
20. Is your mouth constantly dry or do you have difficulty swallowing any food? _____	☐	☐
21. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____	☐	☐
22. Are any teeth sensitive to hot, cold, biting, sweets, or brushing? _____	☐	☐
23. Do you have grooves or notches on your teeth near the gum line? _____	☐	☐
24. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____	☐	☐
25. Do you frequently get food caught between any teeth? _____	☐	☐
GUM AND BONE		
26. Do your gums bleed or are they painful when burshing or flossing? _____	☐	☐
27. Have you ever been treated for gum disease or been told you have lost bone around your teeth? __	☐	☐
28. Have you ever noticed an unpleasant taste or ordor in your mouth? _____	☐	☐
29. Is there anyone with a history of periodontal disease in your family? _____	☐	☐
30. Have you ever experienced gum recession? _____	☐	☐
31. Have you ever had any teeth become loose on their own (without an injury)? _____	☐	☐
32. Have you experienced a burning sensation in your mouth? _____	☐	☐