Raynor Dental

KEENE | PETERBOROUGH | RAYNORDENTAL.COM

PATIENT INFORMATION

Name: _____ Birth Date: _____

Mobile #: _____ Home #: _____

Email: _____ Work Phone #: _____

Home Address: _____ City: _____ Zip: _____

Responsible Party: _____ SS #: _____

INSURANCE INFORMATION

Dental Insurance Carrier: _____ Insurance Phone #: _____

Insured/Employee Name: _____ Insured Birth Date: _____

Employer: _____ Subscriber ID: _____

Group Number: _____

Do you have secondary insurance? ☐ Yes ☐ No

New Patient Survey

Please indicate how important each of these four values are to you:

	Most				Least
Cosmetic					
Function					
Comfort					
Longevity					

Please indicate which of the following would present a potential hesitation for you:

	No Problem				Problem
Time in treatment					
Fear of pain					
Lack of trust					
Budget					

How did you hear about Raynor Dental?

☐ Google ☐ Facebook ☐ Personal Referral ☐ Website ☐ Other Practice

Name/Other:_____

Patient Signature (or legal guardian) _____ **Date** _____

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PATIENT DENTAL INFORMATION

Initial Concern(s): _____

_____

_____

DATE OF LAST DENTAL VISIT	DATE OF LAST DENTAL CLEANING	DATE OF LAST SET OF DENTAL X-RAYS

Mark yes for any of the following that apply to you.

	YES
1. Do you have any dental problems now?	☐
2. Are you dissatisfied with the appearance of your teeth?	☐
3. Do you have mouth pain?	☐
4. Do you have any broken teeth?	☐
5. Do you have teeth that are sensitive to	
a. Hot or Cold?	☐
b. Sweets?	☐
c. Biting or Chewing?	☐
6. Have you ever had	
a. Orthodontic Treatment?	☐
b. Oral Surgery?	☐
c. Periodontal Treatment?	☐
d. A night guard or other appliance?	☐
7. Have you ever noticed any loosening or movement of your teeth?	☐
8. Does food tend to become caught between your teeth?	☐
9. Are you concerned with bad breath?	☐
10. Do you have pain and/or swelling of your gums?	☐
11. Do your gums often bleed when you brush your teeth?	☐
12. Do you ever get sores in your mouth?	☐
13. Do you have sinus problems/infections?	☐
14. Is there any history of allergy to latex?	☐
15. Have you experienced	
a. Clicking of the jaw?	☐
b. Pain (joint, ear, side of face)?	☐
c. Difficulty in opening or closing?	☐
d. Difficulty chewing?	☐
16. Do you	
a. Smoke or Chew tobacco?	☐
b. Clench or grind your teeth while awake or asleep?	☐
c. Bite your lips or cheeks regularly?	☐
d. Hold foreign objects with your teeth (such as pencils, pipe, or fingernails)?	☐
e. Mouth breathe while awake or asleep?	☐
f. Regularly suck on candy or mints?	☐
17. Do you have a history of gagging during dental treatment?	☐
18. Is there anything about your mouth that concerns you?	☐
19. Is there anything about having dental treatment that concerns you?	☐

Please explain: _____

_____

_____

Name (or legal guardian) _____

Patient Signature (or legal guardian) _____ **Date** _____

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PATIENT MEDICAL INFORMATION

Name of your primary care provider _____

Have you ever been hospitalized or had a major operation? ☐No ☐Yes _____

Have you ever had a serious head or neck injury? ☐No ☐Yes _____

Are you taking any medications, pills, or drugs? ☐No ☐Yes _____

_____

Do you take, or have you taken Phen-Fen or Redux? ☐No ☐Yes _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐No ☐Yes _____

Are you on a special diet? ☐No ☐Yes

Do you use tobacco? ☐No ☐Yes

Do you use controlled substances? ☐No ☐Yes _____

Women: Are you:

☐Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐Aspirin ☐Penicillin ☐Codeine ☐Acrylic

☐Metal ☐Latex ☐Sulfa Drugs ☐Local Anesthetics

Other? _____

Do you have, or have you had, any of the following?

	YES	NO		YES	NO		YES	NO		YES	NO
AIDS/HIV Positive	☐	☐	Cortisone Medicine	☐	☐	Hemophilia	☐	☐	Radiation Treatments	☐	☐
Alzheimer's Disease	☐	☐	Diabetes	☐	☐	Hepatitis A	☐	☐	Recent Weight Loss	☐	☐
Anaphylaxis	☐	☐	Drug Addiction	☐	☐	Hepatitis B or C	☐	☐	Renal Dialysis	☐	☐
Anemia	☐	☐	Easily Winded	☐	☐	Herpes	☐	☐	Rheumatic Fever	☐	☐
Angina	☐	☐	Emphysema	☐	☐	High Blood Pressure	☐	☐	Rheumatism	☐	☐
Arthritis/Gout	☐	☐	Epilepsy or Seizures	☐	☐	High Cholesterol	☐	☐	Scarlet Fever	☐	☐
Artificial Heart Valve	☐	☐	Excessive Bleeding	☐	☐	Hives or Rash	☐	☐	Shingles	☐	☐
Artificial Joint	☐	☐	Excessive Thirst	☐	☐	Hypoglycemia	☐	☐	Sickle Cell Disease	☐	☐
Asthma	☐	☐	Fainting Spells/Dizziness	☐	☐	Irregular Heartbeat	☐	☐	Sinus Trouble	☐	☐
Blood Disease	☐	☐	Frequent Cough	☐	☐	Kidney Problems	☐	☐	Spina Bifida	☐	☐
Blood Transfusion	☐	☐	Frequent Diarrhea	☐	☐	Leukemia	☐	☐	Stomach/Intestinal Disease	☐	☐
Breathing Problems	☐	☐	Frequent Headaches	☐	☐	Liver Disease	☐	☐	Stroke	☐	☐
Bruise Easily	☐	☐	Genital Herpes	☐	☐	Low Blood Pressure	☐	☐	Swelling of Limbs	☐	☐
Cancer	☐	☐	Glaucoma	☐	☐	Lung Disease	☐	☐	Thyroid Disease	☐	☐
Chemotherapy	☐	☐	Hay Fever	☐	☐	Mitral Valve Prolapse	☐	☐	Tonsillitis	☐	☐
Chest Pains	☐	☐	Heart Attack/Failure	☐	☐	Osteoporosis	☐	☐	Tuberculosis	☐	☐
Cold Sores/Fever Blisters	☐	☐	Heart Murmur	☐	☐	Pain in Jaw Joints	☐	☐	Tumors or Growths	☐	☐
Congenital Heart Disorder	☐	☐	Heart Pacemaker	☐	☐	Parathyroid Disease	☐	☐	Ulcers	☐	☐
Convulsions	☐	☐	Heart Trouble/Disease	☐	☐	Psychiatric Care	☐	☐	Venereal Disease	☐	☐
									Yellow Jaundice	☐	☐

Name (or legal guardian) _____

Patient Signature (or legal guardian) _____ **Date** _____

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Raynor Dental Office Policies

APPOINTMENTS

Please remember, appointment time is reserved exclusively for you. This enables us to better serve each patient. If it becomes necessary, please reschedule or cancel appointments with our office at least one business day (24 hours) in advance. Our office charges a $45 fee for each hour of time lost due to a late cancellation or missed appointment. As a courtesy, a voice message, text or email reminder concerning appointment information will be left at the phone number/email address you provide at least 48 hours prior to your scheduled appointment.

APPOINTMENTS FOR CHILDREN

We want your children to be comfortable and have a positive experience at every appointment. Toddlers may prefer to sit in a parent's lap during their initial visit and ride in the dentist chair to get comfortable. We have found that, as they get to know us, children do much better in the chair when mom or dad is not in the room. You're welcome to take a "fly on the wall" approach just outside the room where your child doesn't know you are present but you're able to quietly observe. We will never hesitate to have you by your child's side should the need arise.

PAYMENT FOR SERVICES & DENTAL INSURANCE

Payment is due at the time services are rendered. We accept cash, checks, most credit cards, as well as Care Credit. A bank fee will be charged on all returned checks. As a courtesy, we will bill your insurance company for treatment rendered. However, it is the patient's responsibility to know the current status of their insurance coverage and benefits. Our staff will estimate your co-payment based upon the policy information provided by you. This amount will be due at the time of treatment. Actual coverage may vary from our estimate, as your insurance carrier ultimately determines participant eligibility and claim benefits. The financial responsibility for the work you receive in our office is strictly between you and Raynor Dental PLLC, regardless of insurance participation.

PRIVACY

Your privacy is important to us and we will make every effort to protect it, in accordance with federal and state law. You may review our Privacy Practices at any time by requesting a printed version of the document from our staff or by downloading it from our website.

- I understand and agree to the foregoing office policies and I hereby agree to accept responsibility for full payment of all treatment fees regardless of any insurance participation.
- In addition, I hereby acknowledge that I have been given the right to review the Notice of Privacy Practices as required by Federal law.

_____ _____

Printed Name & Signature of Patient or Responsible Party Date