Welcome

JOHN C. REIMERS, D.D.S. • 1120 LONGFELLOW DRIVE • BEAUMONT, TEXAS 77706 • (409) 892-2517

ABOUT YOU

Today's Date: _____ E-mail Address: _____

Name: _____ I prefer to be called: _____ ❑ Male ❑ Female
Last First Mi Mr Mrs Ms Dr

Birthdate: ___/___/___ Age: _____ Social Security #: _____ ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Home Address: _____
Street City State Zip

Home Phone #: (____)_____ Cell/other #: (____)_____ Work Phone #: (____)_____ Ext: ____

Where & when are best times to reach you? _____ Whom may we Thank for referring you? _____

Other family members seen by us: _____

Employer: _____ How long there? _____ Occupation: _____

Employer's Address: _____
Street/PO Box City State Zip

Neighbor or Relative not living with you

His / Her Name: _____ Relation: _____ Work Phone #: (____)_____ Home Phone #: (____)_____

Address: _____
Street City State Zip

Person Responsible for Account if other than yourself

Name: _____ Relation: _____ Home Phone #: (____)_____ Social Security #: _____

Employer: _____ Work Phone #: (____)_____ Ext: ____

Billing Address: _____
Street City State Zip

SPOUSE INFORMATION

His / Her Name: _____ Birthdate: ___/___/___ Social Security #: _____

Employer: _____ Work Phone #: (____)_____ Ext: _____

DENTAL INSURANCE INFORMATION

Primary Insurance

Insurance Co. Name: _____ Phone #: (____)_____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street/PO Box City State Zip

Insured's Name: _____ Insured's Social Security #: _____ Insured's Birthdate: ___/___/___ Relation: _____

Insured's Employer _____ Employer's Address: _____
Street/PO Box City State Zip

AUTHORIZATION

The information on this form is true and correct. I understand that I am responsible for payment of services rendered. If I have dental insurance, I authorize the dentist to release all information necessary to secure the payment of benefits, and I authorize the use of this signature on all insurance submissions, whether manual or electronic. I further authorize Dr. Reimers to use my case and photographs for teaching and promotional purposes.

_____
Signature Date

CONTINUED ON BACK

DENTAL HISTORY

Purpose of today's visit:

Why have you decided to deal with this now?

Have you consulted with any other dentist about this? ❑ Yes ❑ No
If yes, what was discussed or done?

When was your last dental cleaning & check up? _____

Previous Dentist: _____

Do you require antibiotics before dental treatment? ❑ Yes ❑ No
If you have silver fillings, are you interested in replacing them with tooth colored ones? ❑ Yes ❑ No
Does having dental treatment make you nervous? ❑ Yes ❑ No
Are you interested in using nitrous oxide (laughing gas)? ❑ Yes ❑ No
Are you interested in using a premedication such as valium for relaxation prior to dental treatment? ❑ Yes ❑ No
When you think of dental treatment are you concerned about:
Comfort ❑ Yes ❑ No
Cost ❑ Yes ❑ No
Results ❑ Yes ❑ No
Time ❑ Yes ❑ No

Do you now have or have you ever had any of the following?

Y N Bad breath
Y N Gum Disease (gingivitis)
Y N Grind your teeth
Y N Clicking or popping jaws
Y N Jaw Pain or tiredness
Y N Pain around ear
Y N Lip or cheek biting
Y N Loose or broken teeth or fillings
Y N Food collection between teeth
Y N Sores, blisters or growths

Sensitivity to the following:

Y N Cold
Y N Heat
Y N Sweets
Y N Biting/Chewing

Would you like to know what options are available to you to:

1. Create a more Attractive Smile ❑ Yes ❑ No
2. Look Younger ❑ Yes ❑ No
3. Keep your Teeth for life ❑ Yes ❑ No

What would you like to see done now?

_____

_____

_____

MEDICAL HISTORY

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name: _____

Address: _____
Street City State Zip

Phone #: (___)_____ Date of last visit: _____

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ Yes ❑ No

Please explain: _____

Do you smoke or use tobacco in any other form? ❑ Yes ❑ No

Are you allergic to any of the following?

Y N Aspirin
Y N Barbiturates
Y N Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Jewelry / Metals
Y N Latex
Y N Penicillin
Y N Sedatives
Y N Sulfa Drugs
Y N Tetracycline
Y N Other

Please list additional drugs/materials that cause allergic reactions: _____

For Women:
Are you taking birth control pills? ❑ Yes ❑ No
Are you pregnant? Week #: ___ ❑ Unsure ❑ Yes ❑ No
Are you nursing? ❑ Yes ❑ No

Are you taking any of the following?

Y N Acetaminophen
Y N Antibiotics
Y N Antihistamines
Y N Aspirin
Y N Blood Thinners
Y N Blood Pressure Medication
Y N Cold Remedies
Y N Digitalis/Heart Medication
Y N Insulin/Diabetes Drugs
Y N Nitroglycerin
Y N Recreational Drugs
Y N Steroids/Cortisone
Y N Thyroid Medicine
Y N Tranquilizers
Have you ever taken Phen-Fen? Also known as Redux or Pondimin. ❑ Yes ❑ No

Are you taking any prescription/over-the-counter drugs not listed above? ❑ Yes ❑ No If yes, please list each one: _____

Do you or have you experienced the following?

Y N Abnormal Bleeding
Y N Alcohol Abuse
Y N Anemia
Y N Arthritis
Y N Artificial Bones/Joints
Y N Artificial Valves
Y N Asthma
Y N Blood Transfusion
Y N Cancer
Y N Chemotherapy
Y N Chicken Pox
Y N Colitis
Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Drug Abuse
Y N Emphysema
Y N Epilepsy
Y N Fainting Spells
Y N Fever Blisters
Y N Glaucoma
Y N Hay Fever
Y N Headaches
Y N Heart Attack
Y N Heart Murmur
Y N Heart Surgery
Y N Hemophilia
Y N Hepatitis
Y N Herpes
Y N High Blood Pressure
Y N HIV+/AIDS
Y N Hospitalized for Any Reason
Y N Kidney Problems
Y N Liver Disease
Y N Low Blood Pressure
Y N Lupus
Y N Mitral Valve Prolapse
Y N Pacemaker
Y N Persistent Cough
Y N Psychiatric Problems
Y N Radiation Treatment
Y N Rheumatic Fever
Y N Scarlet Fever
Y N Seizures
Y N Shingles
Y N Sickle Cell Disease
Y N Sinus Problems
Y N Steroid Therapy
Y N Stroke
Y N Thyroid Problems
Y N Tonsillitis
Y N Tuberculosis (TB)
Y N Ulcers
Y N Venereal Disease

Please list any serious medical condition(s) that you have experienced: _____