New Patient Information

Kyle W. Shank, DDS • Shank Center for Dentistry

We are committed to excellence in dentistry and appreciate you taking the time to complete this confidential questionnaire. The better we communicate, the better we can care for you. If you have any questions or need assistance, please ask us - we will be happy to help.

Whom may we thank for referring you? _____

ABOUT YOU

Name: _____ I prefer to be called_____ [ ] Male [ ] Female

[ ] Single [ ] Married [ ] Child [ ] Other Birth date: ___/___/___ Age: _____ S.S. #: _____

Home Address: _____ City_____State____Zip_____

Home Phone: (____) _____ Work: (____) _____ ext. ___ Pager: (____) _____

Cell: (____) _____ E-mail Address: _____

Employer: _____ How long there? _____ Occupation: _____

Employer's Address: _____ City_____ State_____ Zip_____

PERSON RESPONSIBLE FOR ACCOUNT

[ ] Same as above Name: _____ Birth date:___/___/___ Relation: _____

Billing Address: _____ City_____State____Zip_____

Home Phone: (____) _____ Work: (____) _____ S.S. #: _____

Employer: _____ How long there? _____ Occupation:_____

SPOUSE INFORMATION

[ ] Same as above Name: _____ Birth date: ___/___/___

Employer: _____ Work Phone: (____) _____ ext. _____

DENTAL INSURANCE INFORMATION

Primary Insurance

Insurance Co. Name: _____ Phone: (____) _____ Group/Policy #: _____

Insured's Name: _____ Insured's Birth date: ___/___/___ Relation: _____

Insured's Social Security #: _____ Insured's Employer: _____

Secondary Insurance

Insurance Co. Name: _____ Phone: (____) _____ Group/Policy #: _____

Insured's Name: _____ Insured's Birth date: ___/___/___ Relation: _____

Insured's Social Security #: _____ Insured's Employer: _____

DENTAL HEALTH QUESTIONNAIRE

We believe that each patient deserves to know what their current level of dental health is, how they got there, and what treatment options are available to help them reach the level of health that they deserve. This begins with a careful diagnosis and personalized treatment plan. We will perform a comprehensive oral examination of your teeth, gums, jaw joints, bite and soft tissues. We will also take the appropriate x-rays, and when beneficial we may take additional diagnostic records such as photographs or casts of your teeth to further evaluate areas of concern.

Once all your records have been completed they will be carefully evaluated to determine your current level of dental health and how you got there. We will review our findings with you and discuss your treatment options. A personalized treatment plan will then be developed to help you achieve the goals we set together.

Please help us better understand your dental health needs and goals by answering the following questions.
(check the best answer):

1. Have you had a full mouth set of x-rays (other than routine cavity detecting x-rays) within the last 5 years? [ ] **Yes** [ ] **No**
2. I have a [ ] **low** [ ] **moderate** [ ] **high** fear of going to the dentist. [ ] **None**
3. My mouth and teeth are [ ] **very** [ ] **moderately** [ ] **not comfortable**.
4. I am [ ] **very satisfied** [ ] **satisfied** [ ] **dissatisfied** with the appearance of my teeth.
5. I think my present state of dental health is [ ] **excellent** [ ] **good** [ ] **fair** [ ] **poor**.
6. I would say that my main concerns with my dental health are: _____
7. I am interested in sedation dentistry. [ ] **Yes** [ ] **No**
8. I am interested in replacing my missing teeth. [ ] **Yes** [ ] **No**

By my signature below, I hereby consent to surgery and/or other treatment and administration of local anesthesia. I authorize my insurance company (if any) to pay directly to Dr. Kyle Shank any benefits relative to my treatment in this office that would otherwise be payable to me. I understand that I am completely financially responsible for all treatment incurred by me in this office, including any amounts not paid by my insurance company (if any) within 60 days of treatment, interest not to exceed a rate of 18% APR on any unpaid amounts more than 60 days past due, and reasonable costs of collection efforts should my account become seriously delinquent.

_____ _____

Signature of patient, or parent/guardian if patient is a minor Date