Mt. Calvary Dental
New Patient Questionnaire

1. What is the main reason for your visit today? _____
2. Are you having a dental problem at this time? _____
3. When was your last dental visit? _____
4. How often do you brush your teeth? _____
5. How often do you floss your teeth? _____
6. Have you ever experienced any of the following problems with your jaw? (Check all that apply)

   ☐ Clicking
   ☐ Pain (joint, ear, side of face)
   ☐ Difficulty opening or closing
   ☐ Difficulty in chewing

7. Have you ever had any head, neck, or jaw injuries? *Yes / No*
8. Do you have frequent headaches? *Yes / No*
9. Do you clench or grind your teeth awake or asleep? *Yes / No*
10. Are you satisfied with the appearance of your teeth? *Yes / No*
11. If you could improve your smile, what would you have done?

    _____

12. Have you ever had an upsetting experience in the dental office?

    Yes / No, If yes, please explain _____

13. Is there anything about you having dental treatment that bothers you?

    Yes / No, If yes, please explain _____

14. I would like to learn more about: (please circle)

☐ Cosmetic Dentistry	☐ Implants	☐ Dentures/Partials
☐ Orthodontics	☐ Bridges	☐ Botox
☐ Whitening	☐ Veneers	☐ Other: _____

15. How did you hear about our practice?

☐ Social Media (Facebook, Instagram)	☐ Referred by: _____
☐ Newspaper	☐ Other: _____
☐ Postcard Mailing	

Mt. Calvary Dental Patient Information and Health History

Patient Name: _____ Date of Birth: _____ Address: _____
Email: _____ Telephone (home): _____ (cell): _____ (work): _____

The following information about your health is very important. It allows us to provide you with the safest possible treatment. Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Please answer all questions thoroughly and accurately. All information is confidential.

Are you under a physician's care now? ☐ Yes ☐ No If yes:_____

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

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

Are you taking any medications, pills or drugs? ☐ Yes ☐ No **If yes:** _____
_____
_____

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

Have you ever taken Fosamax, Boniva, Actonel or any other bisphosphonate medications? ☐ Yes ☐ No If yes: _____

Do you take a blood thinner? ☐ Yes ☐ No If yes: _____

Are you on a special diet? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No

Do you use controlled substances? ☐ Yes ☐ No If yes: _____

WOMEN: Are you…

☐ Pregnant/Trying to become pregnant ☐ Nursing ☐ Taking oral contraceptives

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics
☐ Other _____

Please check if you have, or have had, any of the following:

☐AIDS/HIV Positive
☐Alzheimer's Disease
☐Anaphylaxis
☐Anemia
☐Angina
☐Arthritis/Gout
☐Artificial Heart Valve
☐Artificial Joint
☐Asthma
☐Blood Disease
☐Blood Transfusion
☐Frequent Headaches
☐Low Blood Pressure
☐Lung Disease
☐Mitral Valve Prolapse
☐Osteoporosis
☐Pain in Jaw Joints
☐Parathyroid Disease
☐Psychiatric Care
☐Transient Ischemic Attack (TIA)
☐Acid Reflux/GERD
☐Sleep Apnea
☐Cortisone Medication
☐Diabetes
☐Drug Addiction
☐Easily Winded
☐Emphysema/COPD
☐Epilepsy or Seizures
☐Excessive Bleeding
☐Excessive Thirst
☐Fainting Spells/Dizziness
☐Frequent Cough
☐Leukemia
☐Liver Disease
☐Swelling of Limbs
☐Thyroid Disease
☐Tonsillitis
☐Tuberculosis
☐Tumors or Growths
☐Ulcers
☐Venereal Disease
☐Multiple Sclerosis
☐Anxiety
☐Hemophilia
☐Hepatitis A
☐Hepatitis B or C
☐Herpes
☐High Blood Pressure
☐High Cholesterol
☐Hives or Rash
☐Hypoglycemia
☐Irregular Heartbeat
☐Kidney Problems
☐Stomach/Intestinal Disease
☐Stroke
☐Cancer
☐Chemotherapy
☐Chest Pains
☐Cold Sores/Fever Blisters
☐Congenital Heart Disorder
☐Convulsions
☐Yellow Jaundice
☐Parkinson's Disease
☐Depression
☐Radiation Treatment
☐Recent Weight Loss
☐Renal Dialysis
☐Rheumatic Fever
☐Rheumatism
☐Scarlet Fever
☐Shingles
☐Sickle Cell Disease
☐Sinus Trouble
☐Spina Bifida
☐Breathing Problems
☐Bruise Easily
☐Glaucoma
☐Hay Fever
☐Heart Attack/Failure
☐Heart Murmur
☐Heart Pacemaker
☐Heart Trouble/Disease
☐Infective Endocarditis
☐Human Papillomavirus (HPV)
☐Snoring

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature _____ Date _____

Mt. Calvary Dental
Patient Acknowledgement of Notice of Privacy Practices

You may refuse to sign this acknowledgement

I, _____(*Print Patient Name*), have received a copy of Mt. Calvary Dental's Notice of Privacy Practices.

_____

Patient Signature

_____

Date

Authorization to Release Information

This form is used to obtain authorization to release information regarding you covered under the Privacy Act to people other than yourself. You may refuse to fill this out. This consent is effective until revoked by you. You may revoke this consent at any time by giving written notice to Mt. Calvary Dental. Revocation of this consent will not affect any action we took before we received your written notice of revocation.

I, _____(*Print Patient Name),* authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____

Name Relationship to Patient

_____

Name Relationship to Patient

_____

Name Relationship to Patient

_____

Signature Date

Mt. Calvary Dental
100 Evergreen Road
Mount Calvary, WI 53057
(920) 753-2771

Written Financial Policy

Thank you for choosing Mt. Calvary Dental. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of our mission is making the cost of optimal care as easy and manageable for our patients as possible offering several payment options.

Payment Options:

1. Dental Insurance*: We are happy to work with your carrier to maximize your benefit and directly bill your dental insurance for reimbursement for your treatment.

2. Cash, Check, Debit/Credit Card (Visa, MasterCard, Amex, or Discover):
    - We are pleased to offer you a 5% discount for paying for your treatment prior to completion of care.

3. CareCredit: A convenient option to allow you to pay for your treatment over time, at NO INTEREST and no annual fees or pre-payment penalties. Care credit is subject to credit approval.

Please note:

Mt. Calvary Dental requires payment prior to the completion of treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

A 1.5% monthly fee (18% annually) is charged on any unpaid balance after 60 days.

There is a $35.00 fee for returned checks.

A $50 fee will be imposed for a missed appointment or cancellation less than 24 hours in advance.

If you have any questions, please do not hesitate to ask. We are here to provide you the dentistry you deserve.

Patient, Parent or Guardian Signature Date

Patient Name (Please Print)

*If we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.