CoulonWatts
Health. Beauty. Function.

Our purpose is to help our patients achieve the highest level of total wellness possible, by empowering them to choose the path most appropriate for themselves, and in so doing to enhance the quality of their lives and our own. Please take your time to complete the form so that we can serve you to the fullest.

PATIENT INFORMATION

PATIENT NAME: ______________________ PREFERRED / NICKNAME: ____________

DATE OF BIRTH: _____/_____/_________ ☐ MALE ☐ FEMALE ☐ SINGLE ☐ MARRIED ☐ CHILD

ADDRESS: ______________________ CITY: ____________ STATE:_____ ZIP: ________

HOW DID YOU HEAR ABOUT OUR PRACTICE? ☐ AD ☐ INTERNET ☐ FRIEND / FAMILY ☐ PHYSICIAN ☐ OTHER: ________

HOME PHONE: (______)____________ MOBILE PHONE: (______)____________ WORK PHONE: (______)____________

E-MAIL: ______________________ PREFERRED CONTACT: ☐ TEXT ☐ E-MAIL ☐ CALL MOBILE ☐ CALL WORK

EMERGENCY CONTACT: ______________ RELATIONSHIP: __________ PRIMARY PHONE: (______)____________

TELL US ABOUT YOU

The better we understand you, the better we can serve you. We don't like to make assumptions or guess about what makes you tick.
Please place an **X** along each line indicating which way your opinion or preference leans.

I tend to look at the details	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	I tend to look at the big picture
I prefer long-lasting solutions that may cost more	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	I prefer temporary solutions at a lower cost
My insurance largely determines the extent of my care	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	I largely determine the extent of my care

Are you allergic to any of the following:
- ☐ Aspirin, Ibuprofen, Or Acetaminophen
- ☐ Penicillin
- ☐ Epinephrine
- ☐ Erythromycin
- ☐ Codeine
- ☐ Latex
- ☐ Local Anesthetic (Lidocaine, Novocain)
- ☐ Metals (Gold, Nickel)
- ☐ Nitrous Oxide
- ☐ Sulfa Drugs
- ☐ Other: ______________

Females:
Are you pregnant, or might you be?
☐ Yes ☐ No Due Date: _____/_____/_____

Do you have or have you ever had:
- ☐ Acid Reflux (GERD)
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer - Radiation / Chemo: __________
- ☐ Cyst Or Abnormal Growth
- ☐ Depression
- ☐ Diabetes - A1c: __________
- ☐ Dementia
- ☐ Digestive Disorders
- ☐ Dizziness
- ☐ Epilepsy/ Seizures
- ☐ Fainting
- ☐ Glaucoma
- ☐ Head Injury
- ☐ Hepatitis
- ☐ HIV/Aids
- ☐ Hives/Skin Rash
- ☐ Joint Replacement
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Or Nervous Disorders
- ☐ Pacemaker
- ☐ Respiratory- COPD / Emphysema: __________
- ☐ Sinus Problems
- ☐ Thyroid Or Parathyroid Disease
- ☐ Tuberculosis
- ☐ Other ______________________

Have You Been Told By A Physician To Take Antibiotics Prior To Dental Treatment? ☐ Yes ☐ No Previous Dentist: ______________

Most Recent Dental Exam / Treatment: ☐ Less Than 6 Months ☐ More Than A Year ☐ More Than 5 Years

Have you ever had an oral systemic health assessment? ☐ Yes ☐ No ☐ I don't know

What is your main concern today? ______________________________

Please rate your overall health: Poor ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Excellent

Please rate your dental health: Poor ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Excellent

Continued on other side

TELL US ABOUT YOU CONT'D

Pharmacology:

List all medications you're currently taking, including prescription and OTC meds, vitamins and supplements (include dosage):

____

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Do you have a desire to reduce the amount of medication you currently take? ☐ Yes ☐ No

Caries (Tooth Decay):

- Do you consider yourself cavity prone? ☐ Yes ☐ No
- Do you consume sugary foods or beverages on a regular basis? ☐ Yes ☐ No
- Do you consume any citrus flavored beverages? ☐ Yes ☐ No
- Does your mouth feel dry? ☐ Yes ☐ No
- Do you have heartburn or reflux? ☐ Yes ☐ No

Oral Cancer:

- Do you smoke or chew tobacco? ☐ Yes ☐ No
- Do you have any persistent sore spots in your mouth or lumps/ bumps in your head or neck? ☐ Yes ☐ No
- Do you feel as if you have a lump in your throat? ☐ Yes ☐ No
- Recognizing that HPV infection is the single biggest risk factor for oral/pharyngeal cancer, would you like a saliva ☐ Yes ☐ No test to see if you are at risk? ☐ Yes ☐ No

Concerns:

I am concerned about:

☐ Time ☐ Money ☐ Pain

- I prefer to be sedated during major appointments ☐ Yes ☐ No
- I prefer to be sedated during hygiene appointments ☐ Yes ☐ No

Cardiovascular Health:

- Are you currently being treated for high blood pressure or cardiovascular disease? ☐ Yes ☐ No
- Have you had any heart valves replaced? ☐ Yes ☐ No
- Do you have a history of heart attack, stroke, bypass surgery or stints? ☐ Yes ☐ No
- Do you experience shortness of breath or chest pain? ☐ Yes ☐ No
- Do you have a family history of heart disease? ☐ Yes ☐ No
- Have you ever been diagnosed or treated for high OR low blood pressure? ☐ Yes ☐ No
- If so, is it currently controlled? ☐ Yes ☐ No

Periodontal Disease:

- Have you been told you have gingivitis or gum disease in the past? ☐ Yes ☐ No
- Do your gums ever bleed when you brush or floss? ☐ Yes ☐ No
- Do you have gum recession or exposed root surfaces? ☐ Yes ☐ No
- Do you have any loose teeth, drifting teeth, or areas that collect food when you eat? ☐ Yes ☐ No

Function/ Bite/ TMJ Dysfunction:

- Do you have any missing teeth other than wisdom teeth? ☐ Yes ☐ No
- Do you ever experience discomfort when chewing? ☐ Yes ☐ No
- Do your jaw joints click, pop, or make grinding sounds? ☐ Yes ☐ No
- Do you experience frequent headaches or jaw/facial pain? ☐ Yes ☐ No
- Do your joints ever get stuck or locked? ☐ Yes ☐ No
- Have you ever been treated for a jaw joint problem? ☐ Yes ☐ No
- If so, by what methods:

Cosmetic:

- Are you happy with the appearance of your teeth? ☐ Yes ☐ No
- Are you interested in improving the color of your teeth? ☐ Yes ☐ No

I would like to know my options to:

☐ Improve My Smile ☐ Look Younger ☐ Keep My Teeth For A Lifetime

The most important thing to me is:

☐ Health ☐ Function / Comfort ☐ Beauty

Sleep:

Do you or your bed partner notice that you:

- Ever snore? ☐ Yes ☐ No
- Experience interruptions in breathing during sleep? ☐ Yes ☐ No
- Have difficulty sleeping? ☐ Yes ☐ No
- Feel tired or fatigued during the day? ☐ Yes ☐ No
- Have a sleep study history? ☐ Yes ☐ No
- Have a CPAP or oral sleep appliance? ☐ Yes ☐ No

OUR COMMITMENT TO EXCELLENCE

At Coulon Watts, we place a high emphasis on quality dentistry and make every effort to provide you with the finest care and the most convenient financial options. To accomplish this we work hand-in-hand with you to maximize your insurance reimbursement for covered dental procedures. We will work with your dental insurance provider but we are not in network with any insurance companies. Payment is due at the time service is rendered unless other arrangements have been made in advance.

If we elected to be an “in network” dental provider, we would be compelled to sign contracts with insurance companies, allowing them to dictate the procedures, materials, and fees charged. If we were to practice dentistry as an “in network provider”, we would not be able to serve our patients with the quality that we value and you deserve. We would have to spend less time performing each procedure, use a lower grade of materials, and hire a less competent staff. We do not believe any of these options to be in the best interest of our patients. We value each patient, and refuse to “cut corners.” We hope this information will clarify the limitations of various insurance policies, and your benefits.

______________________________ PATIENT ACKNOWLEDGEMENT

______________ DATE

To the best of my knowledge, all the preceding answers are true and correct. If I have any change in my health or medications, I will inform the doctor at my next appointment. If deemed advisable, I grant permission for my physician to be contacted for details and advice. I further authorize the taking of x-rays, photographs, or other diagnostic measures appropriate for a thorough evaluation.

______________________________ PATIENT SIGNATURE

______________ DATE

______________________________ DOCTOR SIGNATURE

______________ DATE

Acknowledgment Of Receipt Of Notice Of Privacy Practices

I, ______________________________, have received a copy of Coulon Watts Notice of Privacy Practices.

______________________________ PATIENT NAME - *PLEASE PRINT*

______________ DATE

______________________________ PATIENT SIGNATURE