EHMANN DENTAL CARE
General Comprehensive & Cosmetic Dentistry

Date:_____

Patient Name _____
Last First Middle

Home Address _____
Street City/State Zip Code

Contact Numbers _____
Home Work Cell

Email_____

Male ___Female ___ Date of Birth _____ SSN _____

How did you hear about our office? _____

Spouse or Parent/Guardian Name _____ Employer _____

Relationship to patient _____Date of Birth _____ SSN _____

Person Financially Responsible for this account _____ Relationship to Patient _____

Person to contact in case of an emergency _____
Name Relationship Phone Number

Employer_____

Dental Insurance Company _____ Phone Number _____

Policy Holder _____ Relationship to Patient _____

Insurance Claims Address _____
Street City/State Zip Code

ID # (if other than SSN) _____ Group # _____

Do you have secondary coverage? _____

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to doctor otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

Responsible Party Signature ***Relationship to Patient*** ***Date***

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Consent for Treatment

I hereby authorize Ehmann Dental Care to administer such medications and to perform such diagnostic therapeutic procedures as may be necessary for proper dental care as agreed upon through consultation with me. The information, which appears, on these medical / dental histories is correct to the best of my knowledge. I also authorize Ehmann Dental Care to contact my healthcare provider(s) concerning my treatment if necessary.

I give permission for Ehmann Dental Care and the clinical team to take any necessary radiographs, study models and photographs to make a complete diagnosis of my dental needs. I also give permission for Ehmann Dental Care to use my photographs (teeth shots only) for in-office patient education. I consent to the use and disclosure of my protected health information to obtain payment information in connection with my dental claims.

Release of Information

I authorize Kathryn J. Ehmann, DDS, PA and her associates to release and/or send medical/dental information regarding my case to other consulting/or referring physicians/dentists.

Financial Policy Statement

I understand that payment is expected at the time of service. Should timely payments of this account not be made, I authorize Kathryn J. Ehmann, DDS, PA to retain the services of an attorney and/or collection agency to assist with the collection of any outstanding balance. Any expense incurred by such action shall become an additional liability for which I assume responsibility.

Notice of Privacy Practices Availability

I have been informed that I may review Kathryn J. Ehmann, DDS, PA's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent. Furthermore, I understand that the practice of Kathryn J. Ehmann, DDS, PA has the right to change its privacy practices and that I may obtain any revised notices at the practice.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice of Kathryn J. Ehmann, DDS, PA is not required to agree to the request. If the practice of Kathryn J. Ehmann, DDS, PA agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

_____ _____

Patient/Parent/Guardian Signature Date:

Please list the name(s) of individual(s) with whom we may discuss your treatment:

_____ _____

_____ _____

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Medical History

Patient Name:_____

Date of Last Medical Exam _____ Weight _____ Height _____

Physicians name & Phone Number _____

List any medications that you are currently taking
_____
_____

Are you allergic to any medications or substances? _____

Aspirin	Penicillin
Codeine	Acrylic
Metal	Latex Rubber

Are you currently under medical treatment? _____
Is YES, please explain _____

WOMEN ONLY (optional)
Are you pregnant? _____ Is YES, expected delivery date _____
Have you had a Hysterectomy? _____

Please check CIRCLE to indicate if you have had any of the following:

Heart Surgery, disease, attack	Heart Murmur	High Blood Pressure (how is it controlled)
Chest Pains / Shortness of Breath	Mitral Valve Prolapse	Artificial Heart Valve
Pacemaker	Rheumatic Fever	Arthritis/Rheumatism
Cortisone/Steroids	Ankle Swelling	Anemic
Fainting or Dizzy Spells	Stroke (When)	Ulcers
Diabetic (how is it controlled)	Thyroid Problems	Kidney Trouble
Hepatitis (when)	Liver Disease	Yellow Jaundice
Glaucoma	Contact Lenses	Artificial Joints (hip,knee)
Emphysema	Tuberculosis	Asthma
Hay Fever / Allergies	Sinus Trouble	Tonsil / Adenoid Problems or Surgery
Tumor / Cancer	Fatigue Easily	Sickly Cell Disease
Trouble Breathing While Sleeping	Radiation Therapy	Neurological Disorder
Chemotherapy	Venereal Disease	AIDS / HIV Positive
Blood Transfusion	Hemophilia	Psychiatric / Psychological Care
Bruise Easily	Nervous / Anxious	Epilepsy

Significant weight change in the last year? _____Lost / Gained _____

Do you smoke / use smokeless tobacco products_____If YES, how long?_____
Do you VAPE?_____ Do you use any nicotine products?_____

Do you snore / sleep apnea? _____ If YES, please explain _____
Have you undergone any major operations? _____ When? _____

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Dental History

Patient Name _____

Date of last dental visit _____ Last dental cleaning _____ Last X-rays _____

Previous Dentist Name / Address / Phone Number _____

_____

What are your chief concerns today? _____

_____

How often do you brush? _____ Floss? _____

What other dental aids do you use? (Electric toothbrush / water pic / toothpick) _____

Do you experience any of the following? **(please CIRCLE)**

Gum Disease	Bleeding Gums	Decay
Broken Teeth	Bad Breath	Loose teeth
Cold Sores / Fever Blisters	Food Getting Caught	Changes in your Bite

Have you ever had any of the following? **(please CIRCLE)**

Orthodontic Treatment (braces)	Oral Surgery (teeth extracted)	Periodontal Treatment (gums)
Endodontic Treatment (root canals)	Teeth / Bite Adjusted	General Anesthesia (IV Sedation)
Broken Jaw	Missing teeth	Bite Plate / Mouth Guard / Splint

Are your teeth sensitive to: **(please CIRCLE)**

Hot / Cold Biting / Chewing Sweets

Are you satisfied with the appearance of your teeth? _____

Do you think your teeth are affecting your dental health? _____

Do you feel nervous about having dental treatment? _____ What are your concerns?

_____

Have you ever had an upsetting dental experience? _____ If YES, explain _____

_____

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The office of Dr. Kathryn Ehmann & Associates welcomes you! We value our patients and the relationships we have with them. In order to help us form long term relationships with our new patients, we have put together a few questions that will help us get to know you. It will only take a few minutes and would be most helpful. Thank You!

1. What is most important to you about your teeth?
   (Rate each of the following using 3 = extremely important; 2 = somewhat important; 1 = slightly important; 0 = not important.)
   _____ Esthetics – How your teeth look
   _____ Longer visits to complete treatment more quickly
   _____ Keeping your teeth for the rest of your life
   _____ Staying within a budget
   _____ Being as free of discomfort as possible

2. Why did you choose our office?
   _____

3. If you could wave a magic wand and change one thing about the appearance of your teeth, what would it be?
   _____

4. What did you like about previous visits to the dentist?
   _____
5. Why did you leave your last dentist?
   _____
6. How do you feel about your past dentistry? (Rate on a scale of 1 -10 with 10 being the best score)
   _____

7. Rate the present condition of your mouth. (Rate on a scale of 1 -10 with 10 being the best score)
   _____

8. Have you ever considered dental implants as a permanent replacement for any missing teeth?
   YES NO
9. If any major treatment is needed or an important decision made concerning the health of your mouth, would you like to have someone with you at the consultation?
   _____

10. What would you like for us to know to help us make your visits more pleasant?
    _____
    _____

_____
Name

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EROSION RISK EVALUATION

Overall Erosion Risk

Please check all that apply

DIET:

I drink the following...

- ☐ Lemon juice in water
- ☐ Energy drinks
- ☐ Water
- ☐ RTD's or alcopops
- ☐ Vegan diet Vegetarian diet I eat lots of fresh fruit
- ☐ Soft drinks / sodas
- ☐ Vitamin C drinks
- ☐ Sports drinks
- ☐ Wine
- ☐ Kombucha
- ☐ Diet soft drinks/ sodas
- ☐ Herbal tea
- ☐ Freshly squeezed juice
- ☐ Iced tea
- ☐ Flavoured water

CAFFEINE:

- ☐ I drink more than 1 cup of coffee a day
- ☐ I need caffeine for energy I drink energy drinks to stay awake
- ☐ I drink more than 1 cup of tea a day

OCCUPATION:

I do the following in my job...

- ☐ Get stressed
- ☐ Work in an industrial plant with chemicals
- ☐ Taste Wine/work at Vineyard
- ☐ Work long hours
- ☐ Taste Food
- ☐ Taste vinegars and pickles

HEALTH:

- ☐ I wear a mouthguard
- ☐ I rehydrate with gels
- ☐ I participate in endurance sports
- ☐ I rehydrate with sports & electrolyte drinks
- ☐ I use a liquid antioxidant
- ☐ I use liquid or gel vitamin supplements
- ☐ I drink a vitamin drink
- ☐ I have done a detox diet
- ☐ I take a soluble Vitamin C tablet in water
- ☐ I suck vitamin lozenges

MEDICATION:

I take medication for...

- ☐ Anti-histamine
- ☐ Anti-depressant
- ☐ Acne
- ☐ Decongestants
- ☐ Parkinsons Disease
- ☐ High Blood Pressure
- ☐ Anti-Anxiety
- ☐ Nausea or Diarrhea
- ☐ Psychotic Disorders
- ☐ Asthma
- ☐ Reflux

GASTRIC:

I notice frequent...

- ☐ Heartburn
- ☐ Chest Pain
- ☐ I vomit regularly
- ☐ I buy tablets for heartburn
- ☐ Burping/belching
- ☐ Waking at night coughing
- ☐ Acid taste in my mouth
- ☐ I use antacids a lot
- ☐ Dry mouth
- ☐ Cough / Hoarseness
- ☐ Post-nasal drip
- ☐ Laryngitis
- ☐ Reflux or regurgitation

LIFESTYLE:

I like to do the following...

- ☐ Drink wine before bed
- ☐ Use marijuana or other recreational drugs
- ☐ Drink Alcohol
- ☐ Exercise a lot
- ☐ Smoke
- ☐ Party