Smile Sensations
KEVIN J. POTOCSKY, DDS, PC
Changing lives one smile at a time

Welcome to Our Office!

Our Mission Is: We always provide service with a friendly greeting and a smile. We anticipate the needs of our patients. We make all efforts to exceed our patients' expectations. We take ownership of any problem that is brought to our attention. We engage in conduct that enhances our practice reputation and team morale. We are committed to act in the highest ethical manner and respect the rights and dignity of others. We are loyal to our team and our patients and strive for continuous improvement in everything we do.

Patient Information

Name: Mr. Mrs. Ms. _____ Today's Date_____
Last MI First

What would you like us to call you? (preferred name) _____

Street Address _____

City _____ State_____ Zip Code_____

Phone # (Home) _____ (Work)_____ (Cell)_____

E-mail Address _____

How would you like us to confirm your appointments:

E-mail ☐
Phone ☐
Not necessary ☐

Social Security Number _____ Date of Birth_____

Whom may we contact in case of emergency?

Name _____ Phone #_____

Whom may we thank for referring you? _____

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 like to be presented with fewer options		I like to be presented with more options
I tend to look at the details		I tend to look at the big picture
I prefer long-lasting solutions that may cost more		I prefer more temporary solutions at lower cost
My insurance largely determines the extent of my care		I largely determine the extent of my care

(over please)

Primary Insurance and/or Person Responsible for Payment

Name: Mr. Mrs. Ms. _____
Last *MI* *First*

If different from Patient Information

Street Address _____

City _____ State_____ Zip Code_____

Phone # (Home) _____(Work)_____

Social Security Number _____ Date of Birth_____

Employer Name _____

Employer Address_____

Occupation _____

Insurance Company _____

Insurance Phone Number_____

Group Number _____ Contract Number_____

Have you used your insurance this year? ☐ yes ☐ no

Spouse and/or Secondary Insurance

Name: Mr. Mrs. Ms. _____
Last *MI* *First*

Street Address _____

City _____ State_____ Zip Code_____

Phone # (Home) _____(Work)_____

Social Security Number _____ Date of Birth_____

Employer Name _____

Employer Address_____

Occupation _____

Insurance Company _____

Insurance Phone Number_____

Group Number _____ Contract Number_____

To the best of my knowledge, the information above is correct. I realize that this office will provide insurance billing and assist with insurance benefits to the best of their knowledge, however, all charges for services and collection cost for untimely payments are ultimately my reponsibility.

Signature (parent's if minor) X _____ Date_____

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Medical History

Today's Date_____

Patient Name: Mr. Mrs. Ms. _____ Date of Birth_____
Last MI First

Street Address _____

City _____ State_____ Zip Code_____

Phone # (Home)_____ (Work)_____

New Dental Insurance? _____

General Health: ☐ Excellent ☐ Good ☐ Fair Date of last physical _____

Physician's Name_____ Phone_____

Are you under current medical treatment? . . . . . ☐ yes ☐ no

If yes, please explain:_____

Are you currently taking any medications or herbal supplements?. . . . . ☐ yes ☐ no

_____

Do you have any allergies or adverse reaction to drugs?. . . . . ☐ yes ☐ no

If yes, please list_____

_____

Are you on a special diet?. . . . . ☐ yes ☐ no

Have you lost or gained more than 10 pounds in the past year? . . . . . ☐ yes ☐ no

Do you use any form of tobacco? . . . . . ☐ yes ☐ no

What Brand? _____ How Much?_____

Are you interested in quitting? . . . . . ☐ yes ☐ no

Women — (Please circle)

Are you: • Pregnant • Nursing • On hormone therapy • On birth control medication?

Has a Physician ever informed you that you have or have had any of the following?

Rheumatic Fever	☐ yes	☐ no	Respiratory Disease	☐ yes	☐ no
Heart Murmur	☐ yes	☐ no	Intestinal Disease	☐ yes	☐ no
Mitral Valve Prolapse	☐ yes	☐ no	Cancer	☐ yes	☐ no
Other Heart Ailment	☐ yes	☐ no	Chemo/Radiation Therapy	☐ yes	☐ no
Artificial Joints.	☐ yes	☐ no	Liver Disease	☐ yes	☐ no
HIV or Aids	☐ yes	☐ no	Kidney Disease.	☐ yes	☐ no
Hepatitis	☐ yes	☐ no	Major Operations	☐ yes	☐ no
Pacemaker	☐ yes	☐ no	Diabetes	☐ yes	☐ no
High Blood Pressure.	☐ yes	☐ no	Stroke	☐ yes	☐ no
Fainting Spells	☐ yes	☐ no	Psychological/		
Epilepsy	☐ yes	☐ no	Psychiatric Treatment	☐ yes	☐ no
Head Injuries	☐ yes	☐ no	Caffeine Dependency.	☐ yes	☐ no
Blood Disorder	☐ yes	☐ no	Drug/Alcohol Dependency	☐ yes	☐ no
Latex Sensitivity	☐ yes	☐ no	Organ Transplant	☐ yes	☐ no

For Office Use Only

Changes in medical history or medications:

_____

_____ Date_____ Patient's Initial_____

Changes in medical history or medications:

_____

_____ Date_____ Patient's Initial_____

Dental History

When was your last cleaning and examination? _____ Your last dental x-ray taken?_____

Who was your previous dentist? _____ Phone _____

What influenced you to change dentists? _____

What is your immediate dental concern?_____

Please check if you have, or ever had the following:

1. Unfavorable dental experiences . . . . . ☐
2. Dental fears . . . . . ☐
3. Preference for no dental anesthetic . . . . ☐
4. Problems with effectiveness or bad reactions to dental anesthetic . . . . . ☐
5. Orthodontic treatment (braces). . . . . ☐
   When? _____
6. Periodontal (gum) treatment. . . . . ☐
   When? _____
7. Bleeding gums . . . . . ☐
8. Habitual chewing of hard substances, e.g., ice, popcorn kernels . . . . . ☐
9. Part of your mouth is sensitive to temperature . . . . . ☐
10. Lump or bumps on head or neck . . . . . ☐
11. Dry mouth . . . . . ☐
12. Do you have a sugar or soda pop habit? . . . . . ☐
13. An unpleasant taste or odor in your mouth . . . . . ☐
14. Viral infection or cold sores . . . . . ☐
15. Jaw problems (temporomandibular joint). . . . . ☐
16. Difficulty opening your mouth widely . . . ☐
17. Stiff or sore facial muscles . . . . . ☐
18. Awaken with an awareness of your teeth or jaws . . . . . ☐
19. Tension headaches. . . . . ☐
20. Clench or grind your teeth . . . . . ☐
21. Jaw clicking or popping . . . . . ☐
22. How often do you brush?_____
23. How often do you floss? _____
24. Other oral health aids: _____
25. Wearing any oral appliances? _____
26. Wearing any removable teeth? _____

How important is it for you to keep the rest of your teeth for the rest of your life? (circle one):

Not important 1 2 3 4 5 6 7 8 9 1 0 Very Important

How would you rank your smile? (circle one):

Unpleasant 1 2 3 4 5 6 7 8 9 1 0 Beautiful

Please share with us any goals or ideas you may have regarding your oral health or smile:

To the best of my knowledge, the information above is correct. I realize that this office will provide insurance billing and assist with insurance benefits to the best of their knowledge, however, all charges for services and collection cost for untimely payments are ultimately my reponsibility.

Signature (parent's if minor) X _____ Date_____