Dale Petrusha DDS, PC
Creating beautiful, healthy smiles for a lifetime

Patient Information

Patients under the age of 18 cannot be treated unless accompanied by a parent or legal guardian.

Name	(Name you prefer to be called)		Home Phone
Address	City	State, Zip	Work Phone
Email address	Occupation		Cell Phone
Employer	Employer's Address		
How would you like to be contacted? Please check all that apply: Work: ☐Yes ☐No Cell: ☐Yes ☐No Home:☐Yes ☐No Email:☐Yes ☐No Text:☐Yes ☐No			
Social Security #	Date Of Birth	Marital Status	How did you hear of our office?
Previous general Dentist	Address		Phone
Reason for changing Dentist			

Person Responsible For Account _____ Relationship to Patient_____

Name			Home Phone
Address	City	State, Zip	Work Phone
Social Security #	Date Of Birth	Relationship	
Employer	Address		

Primary Insurance Information

Employee Name	
Social Security #	Date Of Birth
Employee #	
Name and Address of Insurance Company	
Employer	
Group #	

Secondary Insurance Information

Employee Name	
Social Security #	Date Of Birth
Employee #	
Name and Address of Insurance Company	
Employer	
Group #	

I hereby authorize payment directly to Dale Petrusha, DDS, PC of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment upon receipt of dental treatment.

X Signed_____ Date _____
(Patient or Parent, if patient is a minor)

How long since your last dental visit _____

Date_____ Purpose_____

Our goal is to make your experience in our office exactly how <u>you</u> want it to be. Please take a few moments to complete this profile so we can make you as comfortable as possible.

Are you in any pain today? □ Yes □ No **What is your chief complaint?**

_____

_____

How important is the cost of treatment and/or insurance coverage in determining your choice of treatment. Please circle:

Important 1 2 3 4 5 Non issue

Please rate, in order of value, what is most important to you in your dental care outside of any pain you may be feeling:

(The most important will be #1.)

_____ Preventing disease in my mouth
_____ Doing only what is necessary at this time: Cost is important
_____ Cosmetically enhancing my smile
_____ Comprehensive treatment; repairing my mouth today and also correcting future problems
_____ Other (please specify) _____

Please rate, as above, what is most important to you in your relationship with a dentist.

____ Show me what he/she is doing or planning to do so I can clearly see what is happening.
____ Listen to my concerns and explain what needs to be done so I can clearly hear and understand my needed treatment.
____ Make sure I feel comfortable and informed at all times.

Have you had any complications after any dental treatment?

□ Yes □ No If yes, please explain: _____

Any bad experience at previous dental visits?

□ Yes □ No If yes, please explain: _____

Please circle the level of fear you have regarding dental treatment. (10 being the most fearful, 1 being the least amount of fear.)

1 2 3 4 5 6 7 8 9 10

Are you concerned about:

Replacing missing teeth □ Yes □ No
Eliminating disease in your mouth □ Yes □ No
Gum Disease □ Yes □ No
Bad Breath □ Yes □ No
The appearance of your smile □ Yes □ No

I would like to know more about these options to maximize my comfort during visits.

Ipod or MP3 player □ Yes □ No
Nitrous Oxide (laughing gas) □ Yes □ No
Sedative Medication □ Yes □ No
Watching movies during treatment □ Yes □ No

Is keeping your natural teeth important to you? □ Yes □ No

When we review your treatment plan, would you like to know (please check one):

_____ The big picture of what needs to be done
_____ All the treatment details along the way