DENTISTRY BY DESIGN
General · Cosmetic · Implant
Leland Judd, D.D.S.

Welcome to Dentistry by Design

Tell us about yourself

Patient's First Name: _____ Last: _____ Middle Initial: _____ Title: Choose

If Child, Parents' First Name: _____ Last: _____

Preferred Name (or nickname): _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ ZIP: _____

SSN: _____ DOB: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Employer: _____ Occupation: _____

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed ◯ Separated ◯ Domestic Partner

Check how you heard about us: ☐ Newsletter ☐ Postcard ☐ Insurance ☐ Radio ☐ Internet ☐ A Friend

Is there someone we can thank for referring you? _____

Do you prefer to be contacted for appointment confirmation via e-mail, text, or phone call? Choose option...

Insurance - Primary

Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____

Subscriber SSN/ID: _____ Subscriber Employer: _____

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone: _____ Group Number: _____

Insurance - Secondary

Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____

Subscriber SSN/ID: _____ Subscriber Employer: _____

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone: _____ Group Number: _____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Dentistry by Design all such benefits, if any, 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 payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____

Relationship: _____ Date: _____

CONSENT: I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Patient/Guardian Signature: _____

Save Page #1

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Medical History

Patient's First Name: _____ Last: _____ Middle Initial: _____ Title:

If Child, Parents' First Name: _____ Last: _____

Patient's Date of Birth: _____ / _____ / _____

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____ Physician's Phone: _____

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

Do you use tobacco? ☐ No ☐ Smoke ☐ Chew

Have you had any artificial joints placed? ☐ Yes ☐ No

Are you taking any medications? ☐ Yes ☐ No

Please list each one: _____

Have you ever had any surgical procedures? ☐ Yes ☐ No

Please list each one: _____

Check all that apply:

Conditions

- ☐ Abnormal Bleeding
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Cancer Chemotherapy
- ☐ Chest Pain
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Drug Abuse
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Facial Surgery

Conditions

- ☐ Fainting Spells
- ☐ Fever Blister
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ HIV + AIDS
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ Joint Replacement
- ☐ Kidney Problems
- ☐ Liver Disease

Conditions

- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Pace Maker
- ☐ Psychiatric Problems
- ☐ Radiation Therapy
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sexually Transmitted Disease
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers

Allergies

- ☐ Aspirin
- ☐ Codeine
- ☐ Dental Anesthetics
- ☐ Erythromycin
- ☐ Jewelry
- ☐ Latex
- ☐ Metals
- ☐ Penicillin
- ☐ Terracycline

If female, please answer:

- ☐ Are you taking birth control pills?
- ☐ Are you pregnant?
  # of weeks: _____
- ☐ Are you nursing?

List any other health issues or allergies we should be aware of: _____

_____

_____

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature: _____ Date: _____

Save Page #2

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Dental History

Patient's First Name: _____ Last: _____ Middle Initial: _____ Title:

If Child, Parents' First Name: _____ Last: _____

How may we help you today? _____

Your currently dental health is: ◯ Good ◯ Fair ◯ Poor

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No If yes, please explain: _____

When was your last dental visit? _____

Do you now or have you had any pain/discomfort in your jaw joint (TMJ)? ☐ Yes ☐ No

Do you clinch or grind your teeth? ☐ Yes ☐ No

Are your teeth sensitive to hot, cold, anything else? ☐ Yes ☐ No

Have you lost any teeth? ☐ Yes ☐ No

Do your gums bleed when brushing or flossing your teeth? ☐ Yes ☐ No

Have you ever had gum treatment? ☐ Yes ☐ No

Do you have well water? ☐ Yes ☐ No

Do you like your smile? ☐ Yes ☐ No

If no, what would you like to change? _____

Are you happy with the color of your teeth? ☐ Yes ☐ No

Have you ever had orthodontic appliances? ☐ Yes ☐ No

Are you interested in straightening your teeth? ☐ Yes ☐ No

Have you ever had a serious/difficult problem with any previous dental work? ☐ Yes ☐ No

Have you ever had any unfavorable dental experiences? ☐ Yes ☐ No

Why did you leave your previous dentist? _____

How can we accommodate you better during your dental visit? _____

At Dentistry by Design we offer a wide variety of services to enhance and keep your smile beautiful. Check any services below that you would like our friendly staff to discuss with you during your visit.

☐ Implants and crowns to replace missing teeth	☐ Periodontal Therapy	☐ Invisalign (Adults & Teens)* (*iTero no-impressions)
☐ Implants to stabilize your dentures	☐ Tooth Color Resin Fillings* *no metal or mercury used	☐ Veneers/Lumineers
☐ Crown and Bridge	☐ Bonding	☐ Smile Makeover
☐ Partials or Dentures	☐ Sealants	☐ Teeth Whitening
☐ Night Guardss	☐ Snore Appliance	☐ Oral Cancer Screening

Save Form #3 | Reset/Erase Entire Form | Submit by Email | Print Form