



# KOCH

A E S T H E T I C  
D E N T I S T R Y

## WELCOME

We are looking forward to having you join our great family of friends and patients. The benefits of a healthy, beautiful smile are immeasurable and our goal is to allow you to obtain the healthy teeth and attractive smile you want and deserve. Please complete this form so that we can provide the best care possible for you.

### About

Today's date \_\_\_\_\_  
Mr./Mrs./Ms./Miss Name: \_\_\_\_\_  
I like to be called: \_\_\_\_\_  
  
Home address: \_\_\_\_\_ City: \_\_\_\_\_  
Zip: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Student: \_\_\_\_\_ School Attending: \_\_\_\_\_  
Date of birth: \_\_\_\_\_ Who may we thank for referring you? \_\_\_\_\_  
Marital status: Single Married Divorced Widowed  
Spouse's name: \_\_\_\_\_  
Do you have dental insurance? \_\_\_\_\_ Parent/guardian name if patient is a minor: \_\_\_\_\_  
\_\_\_\_\_ Employer: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Special interests or hobbies: \_\_\_\_\_

### Telephone

Home phone: \_\_\_\_\_  
Work phone: \_\_\_\_\_  
Cell phone: \_\_\_\_\_  
E-mail address \_\_\_\_\_  
When is the best time to call you? \_\_\_\_\_ and Where? \_\_\_\_\_  
In case of emergency, is there someone we can call?  
Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

# Medical History

Name of personal physician: \_\_\_\_\_ Phone number: \_\_\_\_\_

Last visit with physician: \_\_\_\_\_ Current Health: Excellent Good  
Fair Poor

Do you smoke or use chewing tobacco? Yes No If Yes, How Much Per Day? \_\_\_\_\_

Do you consume alcohol? Yes No If yes, in what quantities? \_\_\_\_\_

Are you currently taking prescription medications? Yes No, if yes, please list below

Name of medication	Purpose

For Women: Are you pregnant? Yes No, if Yes, how many months? \_\_\_\_\_

Do you plan on becoming pregnant in the near future and when? \_\_\_\_\_

Have you had any serious medical problems within the past 5 years? Yes No, if yes, please explain: \_\_\_\_\_

Please **circle** if you have, or have ever had, or been treated for any of the following diseases or medical problems?

- |                        |                      |                       |
|------------------------|----------------------|-----------------------|
| Abnormal bleeding      | Emphysema            | Mitral Valve Prolapse |
| AIDS/HIV               | Epilepsy             | Nervous Disorder      |
| Allergies (Seasonal)   | Excessive Bleeding   | Pacemaker             |
| Anemia                 | Facial/Head Injuries | Prosthetic Valves     |
| Arthritis              | Fainting             | Psychiatric Problems  |
| Artificial Heart Valve | Glaucoma             | Radiation             |
| Asthma                 | Headaches            | Respiratory Problems  |
| Blood Disorder         | Heart Conditions     | Rheumatic Fever       |
| Cancer _____           | Heart murmur         | Rheumatism            |
| Chemotherapy           | Hepatitis/Jaundice   | Scarlet Fever         |
| Depression             | High Blood pressure  | Seizures              |
| Diabetes               | Jaundice             | Stomach Problems      |
| Digestive Problems     | Joint Implants       | Stroke                |
| Dizziness              | Kidney problems      | Thyroid Disease       |
| Drug/Alcohol abuse     | Liver Disease        | Tuberculosis          |
| Eating Disorders       | Low Blood Pressure   | Ulcers                |
|                        |                      | Venereal Disease      |

Have you been treated for any other illnesses not listed above? Yes No, if yes, please explain: \_\_\_\_\_

Do you need to be pre-medicated before dental treatment? Yes No Don't know

Please **circle** if you are allergic to any of the following: Penicillin Aspirin E-mycin  
Codeine Dental Anesthetic Latex

Are you allergic to any other medications? Yes No, if yes, please explain: \_\_\_\_\_

Have you recently or are you currently taking Fosamax, Boniva, Actonel, Pamidronate IV or Zolendronate IV? Yes No

## Dental History

Are you currently in pain or discomfort with your teeth or gums? Yes No, if yes please explain: \_\_\_\_\_

Previous dentist's name? \_\_\_\_\_

Reason for leaving? \_\_\_\_\_

The date of your last dental visit: \_\_\_\_\_ Date of last x-rays \_\_\_\_\_

Date of last oral cancer screening: \_\_\_\_\_ Date of last gum charting: \_\_\_\_\_

Do you have or have you had any of the following: Braces? \_\_\_\_\_ Gum Treatments? \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_ Floss your teeth? \_\_\_\_\_

Do your gums bleed when you brush? Yes No Floss? Yes No

Do you have swollen or irritated gums? Yes No

Do you or have you ever experienced bad breath? Yes No

Have you ever experienced pain in your jaw joint? Yes No

Do you grind or clench your teeth? Yes No

Do you notice your jaw clicking or popping? Yes No

Have you ever been treated for TMJ symptoms? Yes No, if yes please explain: \_\_\_\_\_

Do you notice discomfort in face, head, neck or jaw? Yes No

Are your teeth sensitive to sweets, hot or cold? Yes No Where? \_\_\_\_\_

Are any of your teeth loose? Yes No Are any of your teeth tipped or shifting? Yes No

Have you had any problems with previous dental treatment? Yes No If so, please explain \_\_\_\_\_

Do you need nitrous, oral /IV sedation for dental visits? Yes No

**"If I could change my smile, I would": (circle all that apply)**

- Safely make my teeth whiter
- Make my teeth straighter
- Close spaces
- Replace metal fillings with tooth colored restorations
- Repair chipped teeth
- Replace missing teeth
- Replace old crowns/veneers that don't match
- Have a smile makeover
- Make sure my mouth is healthy

**On a scale of 1 – 10, with 10 being the highest rating:**

-How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

-Where would you rate your current dental health?

**What is the most important thing to you about your dental visit today?**

---

1 2 3 4 5 6 7 8 9 10

**What is the most important thing to you about your future smile and dental health?**

---

To avoid any misunderstandings regarding your dental insurance, we wish our patients to know that **all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees.** We do not render services on the basis that the insurance companies will pay our fees unless a pre-determination of benefits has been established. We will assist you in filing all insurance forms. **Payment is due when services are rendered unless other arrangements have been made.**

I hereby authorize Dr. Koch to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Koch to make a thorough diagnosis of my dental needs. I also authorize Dr. Koch to prescribe any and all forms of medication, and perform any therapy that may be indicated and agreed upon. I give Dr. Koch or his team permission to use any photos he may take to be used for lecturing or educational purposes.

I further authorize the release of any information, including the diagnosis and the records of any treatments or examinations rendered, to my insurance company or consulting professionals. I understand that responsibility for payment for dental services provided in this office for my dependents or me is mine, due and payable at the time services are rendered.

**Signature of patient or responsible party** \_\_\_\_\_

**Date** \_\_\_\_\_

---

# KOCH AESTHETIC DENTISTRY ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**\*\*You May Refuse to Sign This Acknowledgement\*\***

I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
{Please Print Name}

\_\_\_\_\_  
{Signature}

\_\_\_\_\_  
{Date}

---

## For Office Use Only

---

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
  - Communications barriers prohibited obtaining the acknowledgement
  - An emergency situation prevented us from obtaining acknowledgement
  - Other (Please Specify)
- 
- 
- 

© 2002 American Dental Association  
All Rights Reserved

Reproduction and use of this form by dentists and their staff is permitted. Any other use, duplication or distribution of this form by any other party requires the prior written approval of the American Dental Association.

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).