MICHAELS Center For DENTAL EXCELLENCE

POLLY T. MICHAELS, DMD, DABOI/ID, FICOI, FAAID
Diplomate, American Board of Oral Implantology
Board Certified Oral Implantologist

PATIENT INFORMATION (CONFIDENTIAL)

Thank you for choosing Michaels Center for Dental Excellence as your dental care provider. We strive to enthusiastically provide each of our patients with superior oral healthcare and a beautiful smile in a friendly, comfortable and caring environment, with integrity and professionalism, using state-of-the-art technology and materials, while learning and applying the newest dental techniques available. To help us meet all your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us - we will be happy to help!

Date _____ SS# _____

Name _____ Birth Date _____ Phone _____

Address _____ City _____ State _____ Zip _____

Email Address _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Partner

Check Appropriate Box: ☐ Employee ☐ Retiree ☐ Student

Patient's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

How did you hear about our office? _____

Person to Contact in Case of Emergency _____ Phone _____

RESPONSIBLE PARTY

Name of Person Responsible for this Account _____

Relationship to Patient _____

Address _____ Phone _____

Driver's License # _____ Birth Date _____ SS# _____

Employer _____ Work Phone _____

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment is due when services are rendered.

☐ Cash ☐ Personal Check ☐ Debit ☐ MasterCard ☐ Visa ☐ American Express ☐ CareCredit

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DENTAL HISTORY

On a scale of 1 to 5 (1 = low/poor, 5 = high/ excellent) please rate the following:

How do you feel about your overall Dental Health? ☐1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Over the past 10 years, how faithfully have you had your teeth cleaned? ☐1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

What is your level of sensitivity to dental procedures? ☐1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

How do you feel about your smile and the look of your teeth? ☐1 ☐ 2 ☐3 ☐4 ☐5

Please answer the following questions:

Are you self-conscious when you smile? ☐Yes ☐ No

Are there some foods you cannot eat anymore? ☐Yes ☐No

Does it seem like your teeth keep chipping in the front? ☐Yes ☐ No

Do you get food caught in spaces where you are missing teeth? ☐Yes ☐ No ☐ N/A

Do your dentures or partials move around when you speak or eat? ☐Yes ☐ No ☐ N/A

Do you feel like your dentures don't "hold" as well as they used to? ☐Yes ☐ No ☐ N/A

What is the main reason for your visit today?

☐ I need a check-up
☐ Cleaning
☐ Tooth pain
☐ Implants
☐ Cosmetic dentistry
☐ Sedation dentistry
☐ Dentures/Partials/Bridges
☐ Other

I would like to learn more about:

☐ Implants
☐ Cosmetic dentistry
☐ Sedation dentistry
☐ Dentures/Partials/Bridges
☐ Veneers
☐ Whitening
☐ Other

Dr. Michaels is a dedicated educator in the dental community. Your clinical photos and videos may be used to further education, or for social media. If you refuse to participate, please let Dr. Michaels know.