

**Dr. Angeles V. Felix D.M.D.**  
**Dental Associates of Cumberland, LLC**  
*General and cosmetic Dentistry*

Your answers to this confidential questionnaire will help us provide the highest quality care available.

**Tell us about YOU...**

Full Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Date of Birth \_\_\_\_\_ S.S. Number \_\_\_\_\_  
Employer \_\_\_\_\_ How Long? \_\_\_\_\_  
Occupation \_\_\_\_\_ Marital Status \_\_\_\_\_  
Phone #'s: Home \_\_\_\_\_ Cell \_\_\_\_\_  
Work \_\_\_\_\_  
E-mail \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_

**Please describe your dental condition ...**

What is your primary dental concern? \_\_\_\_\_  
\_\_\_\_\_

Circle any of the following that have recently caused pain or sensitivity to your teeth:

COLD    HEAT    SWEETS    TOUCH    CHEWING    SPONTANEOUS

Do you clench or grind your teeth, or think you might?    YES    NO

Do your gums bleed when you brush or floss?    YES    NO

Have your gums receded?    YES    NO

Have you noticed any loose teeth?    YES    NO

Would you say that you have had a MINIMAL, MODERATE, or MAJOR amount of previous dental treatment?

Would you guess that you *need* a MINIMAL, MODERATE, or MAJOR amount of dental treatment now?

Would you say that you have a LOW, MODERATE or HIGH susceptibility to cavities?

Have you ever had any braces or retainers?    YES    NO

Have you had any permanent teeth extracted (other than wisdom teeth)?    YES    NO

About how many? \_\_\_\_\_

When was the last time you had a dental exam by a dentist? \_\_\_\_\_

When was the last time you had a professional dental cleaning? \_\_\_\_\_

Please describe any other dental information that may be important to us: \_\_\_\_\_  
\_\_\_\_\_

## Think about this...

Please consider the following three goals for your dental treatment. All are important, yet not always compatible. Circle the one that seems most important for you:

Longevity

Conserving Enamel

Minimal Cost

## Your medical information...

### Physician's

Name \_\_\_\_\_ Specialty \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_

Are you being treated by a physician now? YES NO

For what reason(s)? \_\_\_\_\_

Are you taking any medications at the present time? YES NO List \_\_\_\_\_

Will you possibly take any recreational drugs in the 48 hrs before any dental treatment?

YES NO

Are you sensitive or allergic to any medications? YES NO which medicines? \_\_\_\_\_

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Have you ever been hospitalized? YES NO List reasons and dates: \_\_\_\_\_

For women only: Are you presently pregnant or possibly pregnant? Yes No

If so, how many weeks? \_\_\_\_\_

Are you presently on any form of birth control? Yes No

If so, which type? \_\_\_\_\_

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## Health Questions...

### HAVE YOU EVER HAD:

Asthma	YES	NO	Arthritis	YES	NO
Heart Disease or Attack	YES	NO	Kidney/Bladder Disease	YES	NO
Tuberculosis	YES	NO	Hepatitis, Cirrhosis, Liver		
Stroke	YES	NO	Disease	YES	NO
Angina Pectoris	YES	NO	Epilepsy or Seizures	YES	NO
High Blood Pressure	YES	NO	Fainting/Dizzy spells	YES	NO
Pacemaker	YES	NO	Diabetes	YES	NO
Heart Murmur	YES	NO	Blood Transfusion	YES	NO
Rheumatic Fever	YES	NO	HIV infection/AIDS	YES	NO
Allergies or Hives	YES	NO	Sickle Cell or Trait	YES	NO
Mitral Valve Prolapsed	YES	NO	Stomach/intestinal		
Joint Replacement	YES	NO	Ulcers	YES	NO
Latex Sensitivity	YES	NO			

**In case of Emergency, contact...**

Name \_\_\_\_\_ Relation \_\_\_\_\_  
Address \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

**About your diet and such...**

Circle the word that best describes your major meals: HEALTHY AVERAGE POOR  
Do you drink coffee, tea, soda? YES NO If yes, about how much per day? \_\_\_\_\_  
Do you chew gum? YES NO Chew Ice or hard candies? YES NO  
Eat lemons? YES NO  
Do you use any form of tobacco? YES NO what form and for how long? \_\_\_\_\_

**About your home dental care...**

Circle the type of toothbrush you use: ELECTRIC MANUAL  
How many times a day do you brush? \_\_\_\_\_ for how Long? \_\_\_\_\_  
Toothpaste: \_\_\_\_\_ Mouthwash: \_\_\_\_\_  
Circle how often you floss? DAILY WEEKLY RARELY NEVER

**Complete this section if someone other than the patient is Responsible for payment...**

Responsible Person's Full Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_ Home # \_\_\_\_\_ Work # \_\_\_\_\_  
Employer \_\_\_\_\_ How Long \_\_\_\_\_ Occupation \_\_\_\_\_  
Date of Birth \_\_\_\_\_ S.S. Number \_\_\_\_\_ Marital Status \_\_\_\_\_

**Dental insurance...**

\_\_\_\_\_  
Patient's Relationship to Insured Employee  
\_\_\_\_\_  
Full Name of Insured Employee  
\_\_\_\_\_  
Insurance Company Policy #

*My signature acknowledges that:  
The questions have been answered truthfully/completely,  
Photographs of me may be used for educational purposes,  
I understand the office policy with keeping appointments,  
I understand and will comply with the office Financial Policy.*

Patient \_\_\_\_\_ Date \_\_\_\_\_

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## **Office Policies**

### **Financial**

1. If you have any questions about fees for planned treatment, please ask us because it is your right to have any questions answered.
2. We request payment in full at time of treatment. We accept cash, checks, visa/master card and debit cards.
3. Our office offers Financing through Care Credit Financial services.
4. Dental Insurance: Our office is a provider for Delta Dental, Blue Cross Dental and MetLife Dental. Our office will only bill secondary insurance if it is one of our primary contracted insurance companies. Patients will be responsible for their own reimbursement on all other secondary insurance companies. For patients who have other insurance, we will gladly submit for reimbursement. All patients are responsible for deductibles, fees and co-payments that your insurance will not cover.

### **Appointments**

Your appointment time has been reserved just for you. If you cannot keep your appointment, we ask you give us 48 hours notice so that we will be able to fill your time slot. Otherwise, our office policy is to charge an hourly rate that covers our overhead.

### **Photography**

Dr. Felix often takes photographs to better explain certain aspects of your existing dental health or planned treatment to you. We request your permission to show these photographs to better explain treatment options to other patients (as you will be shown photos for the same reason.)

*Thank you for giving us the opportunity to help you achieve your dental goals. Our staff will strive to deliver the type of service and atmosphere that you should expect from a superb dental office. We value your opinion and appreciate hearing about the things you like and about the things we could improve to better serve you.*