Personalized Experience
Extraordinary Care

WELCOME TO CITRACADO DENTAL GROUP

Our entire team is dedicated to providing the highest quality and most gentle care to you and your family. It is important for us to understand your needs and concerns about dental treatment so that we may serve you better. Please feel free to add any comments that you believe may assist us in providing ideal dental care for you.

THE CITRACADO TEAM

Wm. R. Jungman, DDS
Julie E. Kangas, DDS
and Associates

PATIENT INFORMATION

NAME ____________________ MR. MRS. MS. DR. ____________________ ____________
LAST FIRST MIDDLE PREFERRED NAME

ADDRESS ____
STREET CITY STATE ZIP

HOME PHONE ____________ BIRTHDATE ______ AGE ____ SOCIAL SECURITY NO. ____________

E-MAIL ADDRESS ______________________________CELL PHONE ______________

IF PATIENT IS A MINOR, PLEASE GIVE PARENT OR GUARDIAN ______________________

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? ______________________

RESPONSIBLE PARTY INFORMATION

NAME ________________________________ ____________ ____________
LAST FIRST MIDDLE MARTIAL STATUS RELATION TO PATIENT

ADDRESS ____
STREET CITY STATE ZIP

HOW LONG AT THIS ADDRESS ______ HOME PHONE ____________ WK PHONE ____________

PREVIOUS ADDRESS (IF LESS THAN 3 YEARS) ______________________________

SOCIAL SECURITY NO. ______________ BIRTHDATE ________ DRIVER'S LICENSE __________

YOUR EMPLOYER __________________ OCCUPATION ______________ YRS. EMPLOYED ____

EMPLOYER ADDRESS ____

SPOUSE'S NAME ________________ OCCUPATION ______________ WK PHONE __________

SPOUSE'S EMPLOYER AND ADDRESS ______________________________________

METHOD OF PAYMENT: ____ CASH ____ CHECK ____ CREDIT CARD CC NO. ______________________

INSURANCE INFORMATION

INSURED'S NAME ____________________ BIRTHDATE ________ SOCIAL SECURITY NO. ____________

INSURANCE COMPANY ________________________ GROUP NO. ____________ POLICY NO. ________

INSURANCE COMPANY ADDRESS ____

DO YOU HAVE SECONDARY INSURANCE? ____ YES ____ NO IF YES, PLEAE COMPLETE THE FOLLOWING:

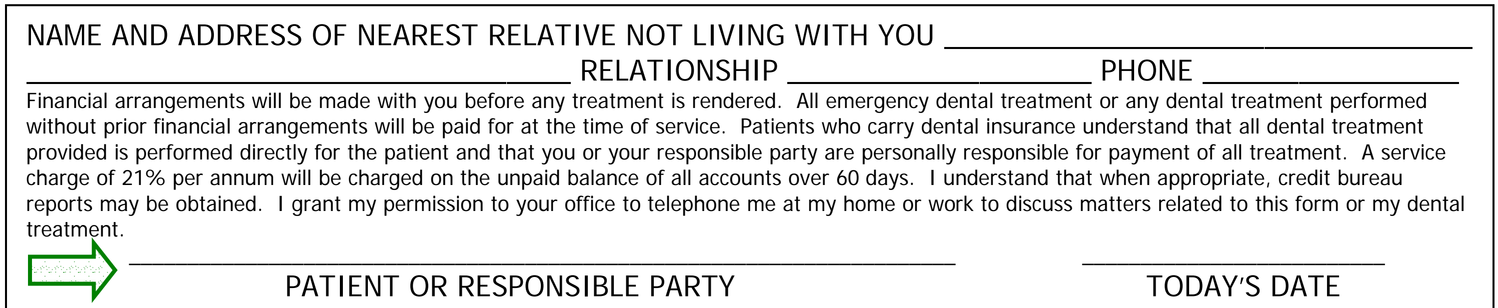
INSURED'S NAME ____________________ BIRTHDATE ________ SOCIAL SECURITY NO. ____________

INSURANCE COMPANY ________________________ GROUP NP. ____________ POLICY NO. ________

INSURANCE COMPANY ADDRESS ____

INSURED'S EMPLOYER ____

EMERGENCY INFORMATION and FINANCIAL AGREEMENT



NAME AND ADDRESS OF NEAREST RELATIVE NOT LIVING WITH YOU ______________________

________________________ RELATIONSHIP ______________ PHONE ____________

Financial arrangements will be made with you before any treatment is rendered. All emergency dental treatment or any dental treatment performed without prior financial arrangements will be paid for at the time of service. Patients who carry dental insurance understand that all dental treatment provided is performed directly for the patient and that you or your responsible party are personally responsible for payment of all treatment. A service charge of 21% per annum will be charged on the unpaid balance of all accounts over 60 days. I understand that when appropriate, credit bureau reports may be obtained. I grant my permission to your office to telephone me at my home or work to discuss matters related to this form or my dental treatment.

____ ____________________
PATIENT OR RESPONSIBLE PARTY TODAY'S DATE

PLEASE COMPLETE OTHER SIDE

MEDICAL INFORMATION

1. General health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Date of last physical exam ____________________

2. Name & address of your physician ____________________
3. Are you now under the care of a physician? ☐ Yes ☐ No
4. Are you taking any drugs or medications? ☐ Yes ☐ No
   Please list ____________________
5. What drugs/medications are you allergic or sensitive to?
   ____
6. Do you have any disease, problem, or condition that we should know about? ____________________
7. Have you ever had antibiotic or other pre-medication before dental treatment? ____________________
8. Do you have any type of prosthetic replacements such as valves, joints, pacemaker? ____________________
9. Do you smoke or use tobacco products? ☐ Yes ☐ No
10. WOMEN: Are you, or might you be pregnant? ☐ Yes ☐ No
    If yes, due date? ____________________
11. Do you have any of the following? (Please circle)

Rheumatic Fever	Respiratory Disease
Heart Surgery	Sinus Trouble
Heart Murmur or Aliments	Asthma or Allergies
Diabetes, Anemia	Fainting Spells
High Blood Pressure	Seizures or Epilepsy
Excessive Bleeding	Kidney Disease
Stroke	AIDS or Test Positive
Herpes	Blood Transfusions
Stomach Ulcers	Arthritis
Metal Sensitivity	Latex Allergy Cancer

Other ____________________

____
CHANGES DATE SIGNATURE

____
CHANGES DATE SIGNATURE

DENTAL INFORMATION

1. Are you having dental discomfort today? ☐ Yes ☐ No
2. What treatment would you like today? ____________________
   ____
3. Are you missing any teeth other than wisdom teeth or Orthodontic extractions? ☐ Yes ☐ No
   Have they been replaced? ☐ Yes ☐ No
4. Do your gums bleed when you brush or floss? ☐ Yes ☐ No
5. Are you concerned about gum disease? ☐ Yes ☐ No
6. Do you have any concerns about the appearance of your teeth? ☐ Yes ☐ No
7. Does it hurt to bite or chew? ☐ Yes ☐ No
8. Does any type of dental treatment make you nervous?
   Please describe ____________________
9. Do you clench or grind your teeth? ☐ Yes ☐ No
   Do you wear a night guard or splint? ☐ Yes ☐ No
10. How do you feel about the overall condition of your teeth & mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
11. Name of your previous dentist: ____________________
    City ____________________ State __________
12. Reason for changing ____________________
    ____
13. How long since your last dental visit and what type of treatment was done? ____________________
    ____
14. Have you ever had a problem with:
    - Local Anesthetic? ☐ Yes ☐ No
    - Previous dental treatment? ☐ Yes ☐ No
    - Nitrous Oxide sedation? ☐ Yes ☐ No
    - Cleaning or periodontal therapy? ☐ Yes ☐ No
15. When was your last cleaning or periodontal therapy?
    ____
16. Do you want to become a regular continuing care patient in our practice? ☐ Yes ☐ No
17. Do you want your mouth properly restored and pain free? ☐ Yes ☐ No
18. The most important concerns regarding my dental treatment are: ____________________
    ____
19. What factors are most important for your satisfaction with our office? ____________________
    ____
20. Do you have any additional concerns or comments?
    ____
    ____

CONSENT FOR PATIENT

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have a change in my health or if my medications change, I will accept responsibility to inform the doctor and other appropriate staff members at my next appointment. I hereby grant authority to the dentist or appropriate staff members in charge of the care of the patient whose name appears on this form to administer anesthetics, analgesics, sedatives, nitrous oxide sedation as may be advised for dental treatment. In addition, I give permission for the performance of such procedures and operation as may be recommended in the diagnosis and treatment of this patient. Should I fail to understand the purpose, procedures, or risks of any treatment to be performed, I will request clarification to my satisfaction. All treatment and services are rendered to the patient and accepted under the terms and conditions printed on the reverse side of this form.

SIGNED ____________________ DATE ____________________

RELATIONSHIP TO PATIENT ____________________

PLEASE COMPLETE OTHER SIDE