Thank You...

...for choosing our dental team for your oral health care needs! We are dedicated to delivering high quality dentistry and taking care of you as a person as well. Before your initial visit, we would like to provide you with some information that may be helpful.

Who are we? Our dental team consists of Deana and Emily up front. Deana is our financial coordinator and schedule coordinator and Emily is our patient coordinator. Trish and Ronda are Dr. Heinrich’s two chair side assistants. Carlynn, Pam and Tamara are the three hygienists. And of course Dr. Heinrich.

What do we do? We provide comprehensive dental care including evaluation and treatment of not only the teeth but also the supporting structures (bone and soft tissue) that hold the teeth in place. We also provide cosmetic dentistry to help enhance your smile and make it white and beautiful. We gain much satisfaction from this type of treatment and have changed many lives by changing people’s smiles. We are also very active in the treatment of implant and reconstructive dentistry as well as sleep dentistry, providing treatment for sleep apnea with a custom made dental appliance. Finally we take care of our patients as if they were part of the family.

At your first visit…depending on how long it has been since you last saw a dentist we may have you see Dr. Heinrich first and one of the assistants will take the necessary radiographs. Dr. Heinrich will discuss your needs and desires with you and then one of the hygienists will clean your teeth. If it has been a number of years since your last cleaning we may ask you to return to finish your initial cleaning and to discuss any other treatment options with Dr. Heinrich. Our goal is to be sure that your initial treatment is completed with quality and that all your questions and concerns are addresses. Deana will also help make sense of your insurance coverage if it applies and discuss financial arrangements if needed. If you have any special needs or concerns prior to your first visit please be sure to let Emily know.

Our visions is… “Building Relationships With Smiles” We hope to build a long lasting relationship with you by building and maintaining your smile. In turn, if you are a smiling patient we would like you to refer your friends and family to our office. This is how we build our practice. We certainly look forward to seeing you.

Please…visit our website at www.heinrichdds.com and LIKE us on Facebook (if you do you name will go in our monthly drawing). We appreciate it.
Welcome To Our Dental Practice
www.heinrichdds.com
10121 N. Nevada Street, Suite 302 • Spokane, WA 99218 • (509) 467-1117

Date____________________

Please answer all questions on both sides, so that we may diagnose your oral health as accurately as possible. All information will be kept strictly confidential. Thank You.

**Whom may we thank for referring you?**

PATIENT’S NAME ___________________________ Preferred Name ___________________________

☐ Married  ☐ Single  ☐ Divorced  ☐ Separated  ☐ Widowed

☐ Male  ☐ Female  Social Security No. ___________ - - - - - - Birthdate _______ / _______ / _______

Mailing Address ___________________________________________________________ Home Phone (____) -

City ___________________________________________ State ___________ Zip Code ___________

Cell (____) - _______ Fax (____) - _______ Email __________________________________________

Name of Spouse ___________________________ Birthday _______ / _______ / _______ Social Security No. _______ - _______

Patient Occupation ___________________________ Employer __________________________________ Work Phone (____) -

Spouse Occupation ___________________________ Employer __________________________________ Work Phone (____) -

How would you prefer to be contacted to confirm appointments?

Email, Text, Phone Call or a Combination? Please list: __________________________

<table>
<thead>
<tr>
<th>PRIMARY DENTAL INSURANCE</th>
<th>SECONDARY DENTAL INSURANCE</th>
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<tbody>
<tr>
<td>Employee_________________</td>
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<td>Employer_________________</td>
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<td>Insurance Co. _____________</td>
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<td>Employee’s S.S. No. _______</td>
<td>Employee’s S.S. No. _______</td>
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</tbody>
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Person responsible for payment: __________________________

IN CASE OF EMERGENCY, WHOM MAY WE CONTACT?

Name ___________________________ Home Ph. No.(____) - ______ Work Ph. No.(____) - ______

Relationship to Patient __________________________

Payment is due in full at time of treatment, unless prior arrangements have been approved. If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all cost of dental treatment. I hereby authorize release of any information, including the diagnoses and records of treatment to my insurance company.

______________________________  __________________________
Signature  Date

Form AD HH 6/18/12
**HEALTH HISTORY**

Chief dental concern: ____________________________

Are you currently taking any medications / drugs? □ Yes □ No
If yes, please list: ____________________________________________________________

List Medications: ____________________________________________________________

Please list over the counter herbs & supplements: __________________________________

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<tr>
<th>Y N</th>
<th>Stroke</th>
<th>Y N</th>
<th>Sickle Cell Disease</th>
<th>Y N</th>
<th>Emphysema / Asthma</th>
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<td>□ Hemophilia</td>
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<td>□ Cough / Tuberculosis (TB)</td>
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<td>□ Liver Disease / Yellow Jaundice</td>
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<td>□ Arthritis / Rheumatism</td>
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<td>□</td>
<td>□ Congenital Heart Defect</td>
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<td>□ Kidney Failure/Disfunction</td>
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<td>□ Venereal Disease</td>
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<td>□ Heart Murmur / Rheumatic Fever</td>
<td>□</td>
<td>□ Thyroid Disease</td>
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<td>□ A.I.D.S. / H.I.V.</td>
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<tr>
<td>□</td>
<td>□ Heart Pacemaker</td>
<td>□</td>
<td>□ Ulcers</td>
<td>□</td>
<td>□ Hepatitis: A B C (circle one)</td>
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<td>□ Artificial Heart Valve</td>
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<td>□ Glaucoma</td>
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<td>□ Frequent Headaches</td>
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<td>□ Diabetes</td>
<td>□</td>
<td>□ Chemotherapy / Cancer</td>
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<td>□ Artificial Joints (Hip, Knee)</td>
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<td>□</td>
<td>□ Blood Transfusion / Anemia</td>
<td></td>
<td>□ Cosmetic Surgery</td>
<td></td>
<td>□ Scarlet Fever</td>
</tr>
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</table>

Have you been diagnosed with sleep apnea? □ Yes □ No

Do you use a CPAP machine to sleep? □ Yes □ No

Women: Are you pregnant? □ Yes □ No Are you nursing? □ Yes □ No Are you taking birth control? □ Yes □ No

Please list any serious medical condition(s) that you have/had: ____________________________

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**Medical History Update** (For Office Use Only)

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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. I also give permission to Dr. Robb Heinrich and his staff to use any photos taken for lecturing and continuing education purposes.

I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

Signature ____________________________ Date ____________________________
Dental History

Date of last dental exam/cleaning and x-rays

Name of previous dentist

Reason for leaving

Check yes or no if you have had any of the symptoms listed below

☐ ☐ Are you having any discomfort at this time?

☐ ☐ Sensitive teeth

☐ ☐ Bleeding gums

☐ ☐ Clicking or popping jaw, pain, TMJ, TMD

☐ ☐ Dry mouth

☐ ☐ Do you clench or grind your teeth?

☐ ☐ Have you ever had any serious or difficult problems associated with any previous dental treatment?

If yes, please explain

☐ Other

How many times each day do you brush your teeth? How many times each week do you floss? 

Do you use an electric tooth brush? If yes, which one?

Periodontal History

☐ ☐ ☐ Have you ever been told you have periodontal disease?

☐ ☐ ☐ Has anyone in your family had/have periodontal disease?

☐ ☐ ☐ Have you ever had periodontal surgery?

How would you rate your dental health on a scale 1 (poor) to 10 (excellent)

How would you rate your overall health on a scale 1 (poor) to 10 (excellent)

Are you happy with the appearance of your smile? Would you like whiter teeth?

Have you whitened your teeth previously? Are you interested in discussing cosmetic dentistry with us?

What is most important to you about your dentist?

What is most important to you about your dental office/team?

Is there anything else you would like us to know about your previous dental experiences?

Is there anything we can do to make your dental visits easier for you?

Do you struggle to have a good night sleep, or know you have Sleep Apnea?