



Thank you for calling our office to schedule an appointment. I am looking forward to meeting you soon! My staff and I are dedicated to making your visits in our office a pleasant experience. **Please complete the information below** and bring it with you to your appointment or you can email it to [sheiladrb@suddenlinkmail.com](mailto:sheiladrb@suddenlinkmail.com).

We always look forward to the comprehensive examination with new patients. Our goal is to create an interactive experience where we listen to you and evaluate all your dental concerns, addressing them in a way that will be helpful and informative.

We usually will call to confirm your appointment and would appreciate your verbal acknowledgement with a return call. Our office policy requires at least 24-hour notice of cancellation or a \$30 fee for missed appointments will be charged. We have found this policy enhances patient care and allows those with urgent situations to be seen as promptly as possible.

I would also like to thank you for visiting our website at [burnettdds.com](http://burnettdds.com). It was designed so that you can get to know us and to provide information about the services we offer.

My staff and I look forward to meeting you soon!

Yours in better health,

Robert D. Burnett, D.D.S.



### Patient Information

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last First MI  
 Male  Female  Married  Single  Child  Other \_\_\_\_\_  
 Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
 Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ (Cell): \_\_\_\_\_  
 Best time to call: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_  
 Preferred appointment times:  Morning  Afternoon  Evening  Any Time  M  T  W  T  F  S  
 Preferred method of contact: \_\_\_\_\_  
 Address: \_\_\_\_\_  
Street Apartment #  
 \_\_\_\_\_  
City State Zip Code

### Health Information

**Have you ever had any of the following? Please check those that apply:**

- |                                            |                                              |                                               |                                             |
|--------------------------------------------|----------------------------------------------|-----------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> AIDS              | <input type="checkbox"/> Excessive Bleeding  | <input type="checkbox"/> Liver Disease        | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Allergies _____   | <input type="checkbox"/> Fainting            | <input type="checkbox"/> Mental Disorders     | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Anemia _____      | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Nervous Disorders    | <input type="checkbox"/> Tumors             |
| <input type="checkbox"/> Arthritis         | <input type="checkbox"/> Growths             | <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Hay Fever           | <input type="checkbox"/> <b>Pregnancy</b>     | <input type="checkbox"/> Venereal Disease   |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Head Injuries       | Due date: _____                               | <input type="checkbox"/> Codeine Allergy    |
| <input type="checkbox"/> Blood Disease     | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Radiation Treatment  | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Cancer            | <input type="checkbox"/> Heart Murmur        | <input type="checkbox"/> Respiratory Problems | OTHER:                                      |
| <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Rheumatic Fever      | <input type="checkbox"/> _____              |
| <input type="checkbox"/> Dizziness         | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism           | <input type="checkbox"/> _____              |
| <input type="checkbox"/> Epilepsy          | <input type="checkbox"/> Jaundice            | <input type="checkbox"/> Sinus Problems       |                                             |
|                                            | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Stomach Problems     |                                             |

Have you been admitted to a hospital or needed emergency care during the past two years?  Yes  No

If yes, please explain: \_\_\_\_\_

Are you now under the care of a physician?  Yes  No

If yes, please explain: \_\_\_\_\_

What medications are you currently taking? : \_\_\_\_\_

Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Do you use cigars/cigarettes, pipe, or chewing tobacco? (circle)

Do you have any health problems that need further clarification?  Yes  No

If yes, please explain: \_\_\_\_\_

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

\_\_\_\_\_  
 Signature of patient, parent or guardian Date: \_\_\_\_\_

## Dental Information

Date of Last Dental Visit: \_\_\_\_\_ Reason for this visit: \_\_\_\_\_

Date of Last Full Mouth X-Rays (16 Small Films or Panoramic): \_\_\_\_\_

|                                                                   | YES                      | NO                       |
|-------------------------------------------------------------------|--------------------------|--------------------------|
| Are you having problems now?                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, what? _____                                               |                          |                          |
| Is your present dental health poor?                               | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you wear dentures? (Partials or Full)                          | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you unhappy with you dentures?                                | <input type="checkbox"/> | <input type="checkbox"/> |
| Would you like to know more about Permanent Replacements?         | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you apprehensive about dental treatment?                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had any Periodontal (gum) treatments?                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you gums bleed, or feel tender or irritated?                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Are your teeth sensitive to hot, cold, sweets, pressure? (circle) | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you aware of grinding or clenching your teeth?                | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have headaches, earaches, or neck pains?                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you worn braces on you teeth (orthodontics)?                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have discolored teeth that bother you?                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Would you like your smile to look better or different?            | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you regularly use dental floss?                                | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had any complications following dental treatment?        | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, please explain: _____                                     |                          |                          |
| Name of Pervious Dentist: _____                                   |                          |                          |
| City: _____ State: _____                                          |                          |                          |

Please RANK the following in the order in which they would  
KEEP YOU FROM having dental treatment.

FEAR of pain # \_\_\_\_\_

LACK of concern # \_\_\_\_\_

COST of treatment # \_\_\_\_\_

MISSING work time # \_\_\_\_\_

## Referral Information

Whom may we thank for referring you to our practice?  Another patient, friend  Another patient, relative  
 Dental Office  Yellow Pages  Newspaper  School  Work  Other \_\_\_\_\_  
 Name of person or office referring you to our practice: \_\_\_\_\_

## Spouse or Responsible Party Information

The following is for:  the patient's spouse  the person responsible for payment

Name: \_\_\_\_\_  
 Male  Female  Married  Single  Child  Other \_\_\_\_\_  
 Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
 Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ Best time to call: \_\_\_\_\_  
 Address: \_\_\_\_\_  
Street Apartment #  
City State Zip Code

## Employment Information

The following is for:  the patient  the person responsible for payment

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Address: \_\_\_\_\_  
Street City State Zip Code

