



Jeffrey S. Rouse, DDS, PA – Specialist in Prosthodontics

Lisa D. Rouse, DDS • Bradly T. Beckel, DDS

Thank you for the opportunity to evaluate your dental condition. In order to provide the best service for you, please complete the following questionnaire.

About You

Last Name:		First Name:
Address:		
City:	State:	Zip:
Home #:	Work#:	Mobile#:
Date of Birth:		S.S.#:
Marital Status:		Employer:
Who can we thank for referring you?		

About Your Spouse

Spouse Last Name:	Spouse First Name:
Date of Birth:	S.S.#
Employer:	Work#:

Insurance Info.

Insurance Company:		
Claims Address:		
City:	State:	Zip:
Contact Phone:		Group#:
Subscriber:	DOB:	Relationship:
Group Name/Employer:		

Additional Insurance Info.

Secondary Dental Plan:	Group#:
Subscriber Name:	DOB:
Group Name/Employer:	S.S.#:

I hereby authorize Dr. Jeffrey Rouse and partners to perform procedures, including but not limited to: giving anesthetics and medications; making radiographs and photographs to be used in professional presentations or journals; performing oral, head, & neck examination, removing and restoring teeth; any necessary prosthodontic therapy. I certify that I have read and fully understand the above consent to treatment. I authorize release of any information necessary to process my insurance claim and, also, hereby authorize payment of insurance benefits to Jeffrey S. Rouse, DDS. A copy of this signature is valid as the original. Your name and signature also indicate that you have received a copy of our Notice of Privacy Practices on the date indicated.

Signature: _____ Date: _____

Medical Health

Name & Address of Physician _____

Have you been under a physicians's care during the past 2 years? No___ Yes___ - if yes, why?

Have you been treated in a hospital in the past 2 years? No___ Yes___ - if yes, why?

Are you now or have you taken any prescription drugs during the past year? No___ Yes___ - if yes, please list?

Have you ever been told that you should be on antibiotics before having dental work? _____

Are you allergic to: Penicillin Codeine Local anesthesia Other _____

Indicate which of the following you have had, or have at present. Circle Yes or No to each item.

Yes No Heart Disease	Yes No Angina	Yes No Jaundice
Yes No HIV	Yes No Arthritis	Yes No Kidney Disease
Yes No Diabetes	Yes No Artificial Heart Valves	Yes No Liver Disease
Yes No Heart Murmur	Yes No Artificial Joints	Yes No Organ Transplant
Yes No Hepatitis	Yes No Asthma	Yes No Pacemaker
Yes No Pregnant	Yes No Cancer	Yes No Polio
Yes No Prolonged Bleeding	Yes No Chemotherapy	Yes No Prolonged Cough
Yes No Rheumatic Fever	Yes No Congenital Heart Lesions	Yes No Psychiatric Treatment
Yes No Stroke	Yes No Drug Dependency	Yes No Radiation Therapy
Yes No Tuberculosis	Yes No Epilepsy	Yes No Sickle Cell Anemia
Yes No Abnormal Blood Pressure	Yes No Fainting	Yes No Thyroid Disease
Yes No Allergies	Yes No Glaucoma	Yes No Ulcers
Yes No Anemia	Yes No Herpes	Yes No Venereal Disease

Do you have any disease, condition, or problem not previously listed? _____

Dental Health

What is the reason for your visit today? _____

When was your last dental visit? _____

Are you having any dental problems that require immediate attention? _____

Do your gums bleed while cleaning or feel tender or sore? _____ Yes No

Do you clench or grind your teeth? Yes No _____

Do your jaws ever feel tired or ache? Yes No _____

Do you have frequent headaches? Yes No _____

Do you have any noticeable wear on your teeth? Yes No _____

Have you had periodontal (gum) treatment? Yes No _____

Is there anything about dental treatments that you would like to know? _____

Smile Assesment

Please consider each statement carefully and circle YES or NO. The doctor and members of our dental team will discuss your responses with you in confidence.

- | | | |
|---|-----|----|
| 1. I am concerned about the appearance of my teeth or my smile. | YES | NO |
| 2. I am concerned about the whiteness/lack of whiteness of one or more of my teeth? | YES | NO |
| 3. I am concerned about the position or angle of one or more of my teeth. | YES | NO |
| 4. I am concerned about the shape of one or more of my teeth. | YES | NO |
| 5. In social situations, I am sometimes embarassed by my teeth or my smile. | YES | NO |
| 6. There are some things about my upper front teeth that I would like to change. | YES | NO |
| 7. There are some things about my lower front teeth that I would like to change. | YES | NO |
| 8. I have old fillings or previous dental treatment that is no longer satisfactory to me. | YES | NO |
| 9. I am missing one or more of my teeth which I may be interested in replacing. | YES | NO |
| 10. I am interested in learning more about esthetic dentistry. | YES | NO |

Please use the space below to indicate any other problems, concerns, or questions. We will make every effort to listen attentively to your concerns so that we can present you with the best possible treatment options. Thank you.



After a certain high level of technical skill is achieved, science and art tend to coalesce in esthetics, plasticity, and form. The greatest scientists are always artists as well. – Albert Einstein