140 Leisure Lane
Columbia, SC 29210
(803) 772 - 9628
www.trinkner.com

Welcome to Tom Trinkner, DDS

We are honored you have chosen our practice. Please help us get acquainted with you.

First Name:_____ Middle Initial:_____ Last Name:_____

I prefer to be called:_____ ☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Street Address:_____ Apt/Ste #:_____

City:_____ State:_____ Zip:_____

Home Phone: ( )_____ Cell: ( )_____ Work: ( )_____

Email Address:_____ Date of Birth:_____ Age:_____

Who may we thank for referring you to our practice?_____

What is your Business or Occupation?_____

What are your hobbies or interests?_____

Spouses/partner's name:_____
Do you have children? ☐ Yes ☐ No If so, please list the names and ages of your children:

_____ Age_____ _____ Age_____

_____ Age_____ _____ Age_____

_____ Age_____ _____ Age_____

_____ Age_____ _____ Age_____

Please list the names and ages of your grandchildren:

_____ Age_____ _____ Age_____

_____ Age_____ _____ Age_____

_____ Age_____ _____ Age_____

_____ Age_____ _____ Age_____

Do you have pets? ☐ Yes ☐ No What type? ☐ Dog ☐ Cat ☐ Bird ☐ Other:_____

Please list the names and type of pets you own:

_____ Type_____ _____ Type_____

_____ Type_____ _____ Type_____

_____ Type_____ _____ Type_____

_____ Type_____ _____ Type_____

Briefly, please tell us the reason for your first visit with us:_____

_____

Dental History

Have you ever experienced any adverse reaction to past dental care? ☐ Yes ☐ No

If yes, please explain:_____

Date of last dental visit:_____ Name of previous dentist?_____

What did you most like about your last dentist?_____

What did you least like about your last dentist?_____

What made you decide to leave your previous dentist?_____

How often do you visit the dentist to have your teeth cleaned? ☐ 3 mo. ☐ 6mo. ☐ 1 yr. ☐ Longer

How often do you brush?_____x a day How often do you floss?_____

On a scale of 1 to 10, with 10 being completely healthy and ideal, how would you rate your oral health?_____

How important is it to you to keep your teeth healthy and looking good for your lifetime?

☐ Extremely Important ☐ Somewhat Important ☐ Not that Important

On a scale from 1 to 10, with 10 being extremely fearful and nervous, please rate your level of fear and/or anxiety regarding your dental care?_____

If you could change anything about your smile or your teeth, what would it be? Please check all that apply.

☐ Whiter ☐ Straighter ☐ Close Spaces ☐ Replace dark fillings

☐ Even Out ☐ Size or Shape ☐ Replace Missing Teeth ☐ Replace partial or full dentures

Are you experiencing any of the following? Please check all that apply.

☐ Clicking, Popping or Locking Jaw ☐ Grinding or Clenching ☐ Jaw Pain ☐ Loose Teeth

☐ Periodontal (Gum) Disease ☐ Sensitivity to Hot/Cold ☐ Sensitivity When Biting

☐ Tension Headaches ☐ Awaken with awareness of teeth/jaw ☐ Bad Breath

☐ Sensitivity When Brushing ☐ Smoker or Tobacco Use ☐ Broken/Loose Fillings

☐ Bleeding Gums ☐ Too much of my gums show when I smile (gummy smile)

Medical History

Have you ever (or been told you) needed to take antibiotics prior to dental appointments? ☐ Yes ☐ No

Please rate your general health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Are you currently under a physician's care? ☐ Yes ☐ No Date of most recent physical exam:_____

Physician Name:_____ Phone: ( )_____

Have you ever had an allergic reaction to any of the following? Please check all that apply.

☐ Latex ☐ Penicillin ☐ Local Anesthetic ☐ Codeine ☐ Aspirin ☐ Tylenol ☐ Ibuprofen ☐ Other_____

Do you have or have you ever had any of the following? Please check all that apply.

☐ Heart Problems ☐ Artificial Prosthesis (Heart Valve, Hip or Knee Replacement) ☐ Digestive Disorder

☐ Chemotheraphy ☐ Mitral Valve Prolapse ☐ Emotional Problems ☐ Diabetes

☐ Arthritis ☐ HIV/AIDS ☐ Psychiatric Treatment ☐ Heart Murmur

☐ Epilepsy, Convulsions, Seizures ☐ Viral Infections or Cold Sores ☐ Stroke

☐ Cancer ☐ High Blood Pressure ☐ Hepatitis (Type_____) ☐ Prolonged Bleeding

☐ Hay Fever ☐ Alcohol Dependency ☐ Drug Dependency ☐ Asthma

☐ Sinus Congestion ☐ Radiation Therapy ☐ Anti-depressant medication ☐ Rheumatic Fever

☐ Eating Disorder ☐ Thyroid Disease

Women: Are you pregnant? ☐ Yes ☐ No Are you taking birth control pills? ☐ Yes ☐ No

Please list all medications you are currently taking and reason for taking them.

Medication_____ For_____ Medication_____ For_____

Medication_____ For_____ Medication_____ For_____

Medication_____ For_____ Medication_____ For_____

Medication_____ For_____ Medication_____ For_____

Please describe any current medical treatment you are undergoing or any impending surgical procedures:

_____

_____

_____

Emergency Contact Information

Name:_____ Phone: ( )_____

Responsible Party Information

Name:_____ Phone: ( )_____

Social Security #_____ Drivers Lic #_____

Dental Insurance/Plan Information

Insurance Company:_____

Policy Holder's Name:_____ DOB:_____

Policy Holder's Employer:_____

Policy Holder's Social Security #:_____

Group #:_____ Subscriber ID#:_____

Patient Responsibility Agreement

- I fully understand that I am financially responsible for any and all charges regardless of the outcome of my insurance. Understanding my insurance benefits is my responsibility.
- I understand that my insurance **will not guarantee** any information that is provided. Tom Trinkner, DDS cannot guarantee the percentage my insurance will cover for treatment.
- I understand that an estimated co-pay will be paid in full at the time services are rendered.
- I understand that there is a $25 processing fee for any check that is returned to the office for non-payment. Only cash, money orders or credit card will be accepted to cover any outstanding balance.
- I understand that if my balance remains unpaid, I will be responsible for any collection and/or legal fees associated with non-payment, including interest charges of 1.5% per diem on my remaining balance.
- I understand that my appointments are reserved exclusively for me, and that real costs are associated with this time. It is my responsibility to provide a minimum of 2 business days notice if I am unable to keep my appointment. Failure to do so may result in a $100 late cancellation fee.
- I hereby consent to the use of anesthetics, sedatives, photography and x-rays.
- I hereby consent, if I give a testimonial, to the use of my image and statements, and all audio, video and photographic recordings of my image and statements in any promotional material relating to Tom Trinkner, DDS.

Signature of Patient/Guardian:_____ Date:_____

If patient is a minor,

Signature of Parent/Guardian:_____ Date:_____

Our Patients With Insurance

As a courtesy to our patients with insurance, Tom Trinkner, DDS will phone your insurance carrier for a breakdown of your benefits and submit the claim form on your behalf.

I understand Tom Trinkner, DDS will act as an advocate on my behalf and wait for reimbursement from my insurance carrier. In doing so, I agree to keep a credit card on file.

Card Type: Visa MasterCard American Express Discover Debit Card

Card Number:_____ Exp._____/_____ CVC:_____

I hereby authorize Tom Trinkner, DDS to charge my credit card per the terms described above.

Signature:_____ Date:_____