

ANN MALOTKY DDS

EXCEPTIONAL DENTISTRY

1800 Buenaventura Boulevard, Redding, CA 96001

Phone: 530-243-8806

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OUR PROMISE TO OUR PATIENTS

The practice of Dr. Ann Malotky provides exceptional dentistry for people of all ages. We offer a wide range of dental services, including preventive dentistry, cosmetic dentistry, restorative and reconstructive dentistry, and neuromuscular dentistry. We pride ourselves on our patient-centered practice. We do everything possible to make dental visits pleasant for our patients. We have earned the loyalty of our patients, many of whom have been with us since our inception in 1985.

PATIENT INFORMATION

(This information is necessary for our files and will be considered confidential)

PATIENT'S LAST NAME FIRST NAME MIDDLE PREFERRED NAME DATE

HOME PHONE CELL PHONE WORK PHONE EMAIL FAX NUMBER

MAILING ADDRESS CITY STATE/ZIP

STREET ADDRESS (IF DIFFERENT FROM MAILING ADDRESS)

SEX: ☐ MALE ☐ FEMALE

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNER ☐ OTHER _____

PATIENT'S BIRTH DATE AGE SOCIAL SECURITY NUMBER CA DRIVER'S LICENSE NUMBER

EMPLOYER NAME EMPLOYER ADDRESS OCCUPATION

SPOUSE'S NAME SPOUSE'S SOCIAL SECURITY NUMBER SPOUSE'S BIRTH DATE

SPOUSE'S EMPLOYER SPOUSE'S OCCUPATION SPOUSE'S WORK PHONE

DENTAL INSURANCE INFORMATION

SUBSCRIBER'S NAME DATE OF BIRTH SUBSCRIBER'S ID OR SSN RELATIONSHIP TO PATIENT

INSURANCE COMPANY GROUP OR POLICY NUMBER GROUP NAME

DENTAL SECONDARY INSURANCE INFORMATION

SUBSCRIBER'S NAME DATE OF BIRTH SUBSCRIBER'S ID OR SSN RELATIONSHIP TO PATIENT

INSURANCE COMPANY GROUP OR POLICY NUMBER GROUP NAME

MEDICAL INSURANCE INFORMATION

SUBSCRIBER'S NAME DATE OF BIRTH SUBSCRIBER'S ID OR SSN RELATIONSHIP TO PATIENT

INSURANCE COMPANY GROUP OR POLICY NUMBER GROUP NAME

SECONDARY MEDICAL INSURANCE INFORMATION

SUBSCRIBER'S NAME DATE OF BIRTH SUBSCRIBER'S ID OR SSN RELATIONSHIP TO PATIENT

INSURANCE COMPANY GROUP OR POLICY NUMBER GROUP NAME

IN CASE OF EMERGENCY NOTIFY (PERSON NOT LIVING AT SAME ADDRESS):

NAME: _____ RELATIONSHIP: _____ PHONE: _____

OTHER INFORMATION

Do you have any family or friends that already come to our office? ☐ No ☐ Yes

How did you find out about our office? (Please check all that apply):

- ☐ Personal referral from _____ ☐ Yellow Pages ☐ Newspaper
- ☐ TV (What program?) _____ ☐ Internet/Website
- ☐ Other Print Media (Please List) _____ ☐ Other _____

DENTAL HEALTH INFORMATION

NAME OF PREVIOUS DENTIST _____

CITY _____

DATE OF LAST VISIT _____

DATE OF LAST DENTAL X-RAYS _____

Are you familiar with the term "Preventative Dentistry"? _____

How often do you brush your teeth? _____

How often do you floss your teeth? _____

Has periodontal disease ever been discussed with you? _____

Do your gums bleed while brushing? _____ Flossing? _____

Do you avoid brushing any part of your mouth because of pain? ☐ No ☐ Yes If yes, what part? _____

Are your teeth sensitive to: ____ Hot ____ Cold ____ Sweets ____ Sours ____ Chewing

Do your gums feel tender or swollen? _____

Have you ever had braces? _____ When? _____

Do you clench or grind your jaws while sleeping or during the day? _____

Do your jaws ever feel tired? _____

Do you chew ice? _____

Have you ever had any teeth extracted? ☐ No ☐ Yes If yes, when? _____

Do you have any implants? _____ How many? _____ Who did them? _____

Do you wear or have you ever had dentures or partials? ☐ No ☐ Yes If yes, explain what type and date of original placement _____

Do you usually have many cavities? _____

Do you lose or break fillings? _____

Do you gag easily? _____

What do you think about your mouth's current state of health? _____

Is there anything you'd like to change in the appearance of your teeth: i.e. color, shape, spacing, or other?

☐ No ☐ Yes If yes, please explain: _____

What additional information would you like us to know? _____

We provide a variety of services to assure that you are comfortable. Please select from the following menu if you prefer any of these options:

- We provide various levels of sedation: Nitrous Oxide (laughing gas), mild sedatives
- Our rooms are equipped with iPod capability (you are welcome to provide your own iPod and music). What type of music do you like? _____
- Blankets help keep you warm and relaxed through your visit. Would you like a blanket?
☐ No ☐ Yes
- Pillows provide an extra measure of comfort whether you have a sore back or you would just like something to hold onto. Would you like pillows? ☐ No ☐ Yes
- Is there anything else we can do for you to make your visits as comfortable as possible?

Dr. Malotky prefers to use real clients in the promotion of her practice, therefore, we would like to have your authorization to use your photos, videos and/or testimonials in our advertising.

Please accept or decline below.

PHOTOGRAPHIC, VIDEO AND TESTIMONIAL RELEASE AND CONSENT

I hereby grant to Ann Malotky DDS and her representatives the irrevocable and unrestricted right to reproduce and display photographs, videos and testimonials of me in print, on her website, or any other lawful purpose for advertising. I release Ann Malotky DDS and her employees and legal representatives from any and all claims, actions and liability relating to its use of said photographs, videos and testimonials.

Printed Name: _____

Date: _____

Signature: _____

_____ I accept _____ I decline