Dennis K. Sacry DDS
108 First Street West P.O. Box 549 Whitehall, MT 59759
406-287-3026 Fax 406-287-3014

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of Dennis K. Sacry DDS's Notice of Privacy Practices, which has an effective date of 10 / 1 / 2013, and which describes how my health information may be used and disclosed.

I understand that you have the right to change the Notice of Privacy Practices at any time, that I will be provided a copy of any updated version, and that I may contact you at any time to request a current Notice of Privacy Practices.

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices:

_____ _____

Signature of Patient or Patient's Representative Date

_____

Print Name

_____

Relationship to Patient (If not signed by the Patient)

DENNIS K. SACRY D.D.S., PC

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We would like to get to know you better!

Date ______________

Name ______________________________ Male ☐ Female ☐

Residence ______________________________ Zip __________

If Child; Parent Name ______________________________

Phone ______________ Occupation ______________ Employer ______________

Address ______________________________ Phone ______________

Date of Birth ______________ Age ________ Spouse's Name ______________

Spouse's Occupation ______________ Employer ______________

Address ______________________________ Phone ______________

Who referred you to our office? ______________________________

Person responsible for dental investment ______________________________

AFTER INSURANCE OR NO INSURANCE PLEASE CHOOSE CASH______ CREDIT CARD____ CARE CREDIT____

For Insurance Purposes:

Name of Carrier ______________________________

Social Secuity Number ______________ Group Number ______________

Are you covered by another plan? ______________ Is so, Name of Carrier ______________

Social Secuity Number ______________ Group Number ______________

★★★

Are your teeth sensitive to:	YES	NO
Heat?	☐	☐
Cold?	☐	☐
Sweets?	☐	☐
Biting Pressure?	☐	☐
Does food catch between your teeth?	☐	☐
Do your gums bleed when brushing?	☐	☐
Have you noticed any gum swelling around any teeth?	☐	☐
Do you have an unpleasant taste or odor in your mouth?	☐	☐
Problems of the Jaw:		
Clicking of the jaw	☐	☐
Pain (joints, ear, side of face)	☐	☐
Difficulty opening or closing	☐	☐
Difficulty chewing	☐	☐
Do you ever avoid any part of the mouth while brushing?	☐	☐
Have you had a reaction to local anesthetic?	☐	☐
Are you dissatisfied with your teeth and their appearance?	☐	☐
Are you deeply concerned about the finances required to return your mouth to excellent dental health?	☐	☐
Do you get frustrated because you always have something to be treated or repaired when you visit a dentist?	☐	☐
Do you smoke? (Tobacco)	☐	☐
Have you every had any teeth removed?	☐	☐
How long have these teeth been missing? ______________		
Do you feel you will eventually wear artificial dentures?	☐	☐
Do you have any fears?	☐	☐

When was your last dental appointment? ______________	YES	NO
Do you have any general health problems?	☐	☐
If so, please specify ______________		
Have you had surgery?	☐	☐
If so, please specify ______________		
Are you currently under a physician's care?	☐	☐
Reason ______________		
Any Medications? ______________	☐	☐
To the best of you knowledge, are you or have you ever been afflicted with:		
Heart Ailment ______________	☐	☐
Diabetes	☐	☐
Rheumatic Fever	☐	☐
Epilepsy	☐	☐
High Blood Pressure	☐	☐
Respiratory Disease (Cough - Asthma)	☐	☐
Hepatitis	☐	☐
HIV Positive	☐	☐
Prolonged Bleeding	☐	☐
Healing Complication	☐	☐
Allergy to any Drugs (Foods & Latex) ______________	☐	☐
Are you Pregnant, Month ______________	☐	☐

Why did you leave your last dentist?

____

What is your present dental problem?

____

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Welcome to our office. This information is important to us in treating and getting to know your child. Please answer all questions to the best of your knowledge.

Child's Name _____ Date _____

Date of Birth _____ Age _____ Grade in School _____

Father's Name _____ Occupation _____

Mother's Name _____ Occupation _____

Mailing Address _____ Zip _____

Home Phone _____ Cell # _____ Work Phone _____

Person responsible for account: Father _____ Mother _____ Other _____ Insurance _____

Is this your child's first visit to the Dentist? Yes _____ No _____ Emergency _____

Has your child ever had any of the following: [Please circle all that apply]

Oral Pain Broken Teeth Extracted Teeth Cavities Toothache Gum Infections

Is there now or has there ever been any of the following: [Please circle all that apply]

Anemia Emotional Problems Heart Defects Rheumatic Fever Asthma Epilepsy

Kidney Disease Speech Impediment Convulsions Excessive Bleeding Liver Disease

Tuberculosis Diabetes Hearing Problems Mental Illness Tumors Other

Does your child have any allergies? _____

Is your child under a physician's care? Yes No For What? _____
Name & address of Physician _____
Does your child have any illness now or any problems not listed above? -------- Yes No
Has your child had any surgeries? ---------- Yes No
Please List_____
Has your child complained about dental problems? ---------- Yes No
Has your child had any injuries to mouth/teeth/head? ---------- Yes No
Does child have mouth habits - Finger Sucking/Nail Biting/Mouth Breathing? Yes No
Does child brush their teeth?_____ How Often? _____ Do you help?_____
Whom may we thank for referring you to our office? _____

Signature of Parent or Guardian:_____