

Roger J. Fisher, D.D.S.

All Smiles Dentistry ~ for all the family



Roger J. Fisher, D.D.S.
All Smiles Dentistry ~ for all the family

Roger J. Fisher DDS PC

5801 S. 58th Street, Suite AA
Lincoln, NE 68516
www.rogerfisherdds.com

office: 402-488-2727
fax: 402-488-4263
new patients: 402-420-0999
allsmilesdent@neb.rr.com

Today's Date _____ Appt. Date _____

Patient Name: _____ Sex: M F Date of Birth _____

If patient is a minor, parents name: _____

Marital Status: M S D W Spouse's Name: _____

Street Address _____ City, State, Zip _____

Home Phone : _____ Business Phone _____ Cellular _____

Employer _____

Do you have Insurance to assist you with your payments? Y N

Payment will be made at time of service (Co-payment)

Cash-Check Credit Card Care Credit Payment Plan (No Interest)

Name of Person who is the Insurance policy holder _____

DOB _____ SS# _____ Employer _____

Insurance Carrier _____ Phone _____

Additional Insurance Carrier _____

Are you having any dental concerns at this time? How can we help you?

To help with our exam circle any of the below that apply to your present condition?

What area of the mouth _____ **How long a problem** _____

Lost filling - Broken tooth Is it a Ache or Shooting Pain Hot Cold

Swelling - Pressure ON/ Off/Constant Do you have Allergies _____

"Whom may we thank for telling you about our office?"

Have you ever had any unfavorable experience from previous medical or dental treatment, anesthetics (shots), drugs, or medications?"

Are you anxious or apprehensive about dental care? Y N

Have you ever been told you need to take antibiotics prior to dental visits. Y N

What pharmacy do you use _____ RX _____ Phone _____

Are there any other family members who may need an appointment Y N

Name and Age _____

"Would you like to improve your smile?" Y N

Explain if you have tried anything up to now? _____

How would you want to improve it?

Would you like to know more about?

Braces - Invisalign - Whitening (Zoom) - Veneers(Laminates) - Implants

Date of last dental visit _____ What was done _____

How often did you get your teeth cleaned ? every __ months, yearly? _____

Does your jaw ever ache, pop, click, clench or grind your teeth? Y N

When was your last full mouth X-Ray (16films or a Panorex)? _____

In order to save time, please arrive 1/2hr early, especially if you do nothave a history in the past five years of full mouth X-rays. We appreciate you becoming our patient.