Patient, Pharmacy and Insurance Information

Patient Information

Prefix: _____ First Name: _____ Middle Name: _____ Last Name: _____

Suffix: _____ Preferred Name: _____ Today's Date: _____

Street: _____ Zip: _____ City: _____ State: _____

Preferred Phone #: _____ Is this a mobile number? Yes ❑ No ❑ Secondary Phone # _____

Email Address: _____

Date of Birth: _____ Sex: ❑ Male ❑ Female ❑ Unspecified

Emergency Contact: _____ Emergency Phone #: _____

How did you hear about us? ❑ Internet/Social Media ❑ Friend/Family ❑ Drive By

Responsible Party (if under the age of 18)

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

Street: _____ Zip: _____ City: _____ State: _____ Country: _____

Date of Birth: _____ Sex: ❑ Male ❑ Female ❑ Unspecified

Responsible Party Signature: _____ Date: _____

Preferred Pharmacy

Name: _____ Phone Number: _____

Street: _____ Zip: _____ City: _____ State: _____

Primary Dental Insurance

Is the subscriber the same as patient? Yes ❑ No ❑

Subscriber Information:

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

Employer Name: _____ Insurance Company: _____

Ins. Phone Number: _____

Subscriber ID/Policy Number: _____ Group/Contact Number:_____ Date of Birth: _____

Patient Relationship to Subscriber: ❑ Child ❑ Disabled Dependent ❑ Husband ❑ Self ❑ Wife ❑ Other Dependent

Subscriber SSN: _____

Secondary Dental Insurance

Is the subscriber the same as patient? Yes ❑ No ❑

Subscriber Information:

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

Employer Name: _____ Insurance Company: _____

Ins. Phone Number: _____

Subscriber ID/Policy Number: _____ Group/Contact Number:_____ Date of Birth: _____

Patient Relationship to Subscriber: ❑ Child ❑ Disabled Dependent ❑ Husband ❑ Self ❑ Wife ❑ Other Dependent

Subscriber SSN: _____

Health History

Reason for Visit: ❑ Broken Tooth ❑ Check-up ❑ Cosmetic ❑ Dentures ❑ Tooth Pain ❑ Other:_____

Are you under the care of a primary physician?: ❑ Yes ❑ No

Primary Physician's Name: _____ Physician's Phone Number: _____

Date of Last Physical:

❑ I don't know exact date ❑ Last 6 months ❑ 6 months - 1 year ❑ 1-3 years ❑ Greater than 4 years ❑ Never ❑ Other_____

Are you taking or have you taken any steroid/cortisone therapy in the last 2 years? ❑ Yes ❑ No

Have you ever been hospitalized? ❑ Yes ❑ No

Are you taking or have you taken Oral Bisphosphonates (e.g., FOSAMAX, BONIVA) or IV Bisphosphorates (e.g., ZOMETA, AREDIA)?

❑ No ❑ Yes How Long? _____

Do you require antibiotics prior to dental procedures? ❑ Yes ❑ No

Are you allergic or have you had an adverse reaction to any of the following?

❑ None ❑ Amoxicillin ❑ Aspirin ❑ Codeine ❑ Epinephrine ❑ Latex

❑ Metals ❑ Novocaine ❑ Penicillin ❑ Sulfa ❑ Tetracycline ❑ Other: _____

List any medications you are taking including non-prescription drugs and herbals/vitamins:

❑ None

_____

_____

_____

_____

_____

_____

Check any conditions that apply to you:

❑ **None**
❑ Alcoholism
❑ Allergies or Hives
❑ Anemia
❑ Arthritis
❑ Artificial Joint/Pins
Type: _____
Age: _____
❑ Aspirin Therapy
❑ Asthma
❑ Blood Thinners
❑ Blood Transfusion
❑ Breathing Problems
❑ Cancer
Type: _____
❑ Chemotherapy
❑ Coumadin Therapy
❑ Dementia
❑ Diabetes
Type: _____

❑ Drug Addiction
❑ Epilepsy
❑ Excessive Bleeding
❑ Fainting/Dizziness
❑ None
❑ Hearing Impairment
❑ Heart Murmur
❑ Heart Surgery
Date: _____
❑ Heart Trouble
Type: _____
❑ Hepatitis
Type: _____
❑ High Blood Pressure
❑ HIV
❑ Kidney Disease
❑ Liver Disease
❑ Low Blood Pressure
❑ Lung Disease/COPD
❑ Lupus
❑ Mitral Valve Prolapse
❑ Mobility Impairment

❑ NON-DENTAL Implants
Type:_____
❑ Organ Transplants
Type: _____
❑ Pace Maker
❑ None
❑ Psychiatric Care
❑ Radiation Threapy
❑ Radiosurgery
❑ Rheumatic Fever
❑ Seizures
❑ Sexually Transmitted Disease
❑ Sinus Problems
❑ Stomach Problems
❑ Stroke
❑ Thyroid Disease
❑ Tuberculosis (TB)
❑ Ulcers
❑ Visual Impairment
❑ None
❑ Other Disease/Illness
Type:_____
_____

Dental History

Date of Last Dental Visit:

❑ I don't know exact date ❑ Last 6 months ❑ 6 months-1 year ❑ 1-3 years ❑ Greater than 4 years ❑ Never ❑ Other_____

Date of Last Dental X-ray:

❑ I don't know exact date ❑ Last 6 months ❑ 6 months-1 year ❑ 1-3 years ❑ Greater than 4 years ❑ Never ❑ Other_____

Oral Health

Have you ever been treated for periodontal (gum) disease?: ❑ Yes ❑ No

Have you ever had Novocaine or other local anesthetic?: ❑ Yes ❑ No

How happy are you with your smile (1-10)? _____

Are you currently wearing dentures?: ❑ Yes ❑ No

Age of dentures?: ❑ Less than 6 months ❑ 6 months - 3 years ❑ Greater than 4 years

Please check any conditions that apply to you below:

❑ Pain in Jaw (TMJ) ❑ Teeth Grinding/Clenching ❑ Use tobacco products ❑ Mouth Sores

❑ Sensitive Teeth ❑ Broken/Loose Teeth ❑ Difficulty Chewing/Swallowing ❑ Swollen/Bleeding Gums

Women Patients Only

Are you currently pregnant? ❑ Yes ❑ No Estimated Delivery Date:_____

Are you Nursing? ❑ Yes ❑ No Are you taking any birth control prescriptions? ❑ Yes ❑ No

**NOTE Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

I certify that I have read and understand the above questions and acknowledge that questions have been answered to the best of my knowledge. I hereby give my consent to the dentist to perform an examination and diagnose my condition. I also give my consent for any preventive or basic restoration procedures which may be necessary. I understand that this consent will remain in effect until treatment is terminated either by me or the dentist.

Patient's Signature: _____ Date: _____

Dr.'s Signature/Medical History Review: _____Date: _____

6 MONTH UPDATE

Patient's Signature: _____ Date: _____

Dr.'s Signature/Medical History Review: _____Date: _____