Patient Medical History

Patient's Name ______________________________ **Date of Birth** ______________________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

Yes No

1. Are you in good health? ______________________
2. Have there been any changes in your general health within the past year? ____________________
3. Date of your last physical exam ____________________________
4. Physician's name____________________________
   Address______________________________
   Phone No.____________________________
5. Are you now under the care of a physician? _______
6. Have you ever been hospitalized for any surgical operation or serious illness? ____________________
   Please explain ______________________________________
7. Are you taking any medicine(s), including non-prescription medicine? ____________________
   If yes, what medicine(s) are you taking? _____________________
   ____

Yes No

Are you **allergic** to or have you had reactions to:

Local anesthetics like Novocain_________________
Penicillin or other antibiotics____________________
Sulfa drugs _________________________________
Barbiturates, sedatives, or sleeping pills __________
Aspirin ___________________________________
Iodine ____________________________________
Any metals (e.g., nickel, mercury, etc.) ___________
Latex/rubber ______________________________
Other (please list) ___________________________________

Do you have, or have you ever had, any of the following:

Rheumatic heart disease or rheumatic fever ______
Scarlet fever ______________________________
Heart defect or heart murmur, mitral valve prolapse
Heart trouble, heart attack, or angina ___________
Chest pain ________________________________
Shortness of breath __________________________
Pacemaker _________________________________
Heart surgery ______________________________
High/low blood pressure _____________________
Congenital heart problem ____________________
Swelling of feet, ankles, hands _________________
Hepatitis, jaundice, or liver disease _____________
Stroke ____________________________________
Sinus trouble _______________________________
Lung or breathing problems __________________
Asthma or hay fever ________________________
Hives or skin rash ___________________________

Yes No

8. Have you had any abnormal bleeding? ___________
9. Do you bruise easily? ________________________
10. Have you ever required a blood transfusion? ______
11. Have you had a recent weight loss? ____________
12. Have you ever taken Fen-Phen or Redux? ________
13. Tobacco user?_____________________________
    snuff cigarettes cigar pipe chew
14. Do you or have you used controlled substances?___
15. Are you wearing contact lenses? _______________

Fainting or dizzy spells_______________________
Diabetes _________________________________
AIDS or HIV infection ________________________
Thyroid problem ____________________________
Allergies _________________________________
Arthritis or rheumatism_______________________
Joint replacement or implant __________________
Stomach ulcer _____________________________
Kidney trouble _____________________________
Tuberculosis _______________________________
Persistent cough____________________________
Cough that produces blood ___________________
Chemotherapy (cancer, leukemia) _____________
Sexually transmitted disease__________________
Epilepsy or seizures_________________________
Anemia __________________________________
Glaucoma ________________________________
Nervousness ______________________________
Tonsillitis_________________________________
Tumors __________________________________
Mental health care __________________________
Back problems _____________________________
Chemical dependency _______________________
Cortisone treatment ________________________
Cold sores/fever blisters ____________________
Hypoglycemia______________________________
Eating disorders ____________________________

Women Only

1. Are you pregnant or think you may be pregnant? ___
2. Are you nursing?____________________________
3. Are you taking birth control pills? _______________

Patient Dental History

Patient's Name ______________________________ **Date of Birth** ______________________

Reason for this visit ______________________________

When was your last dental visit? ____________________ What was done then? ____________________

How often did you visit the dentist before then? ______________________________

Previous dentist (name and location) ______________________________

Have you had a complete series of dental exams (x-rays) taken? When and where ______________________________

How often do you brush your teeth? ____________________ How often do you floss your teeth? ____________

Is your drinking water fluoridated? ______________________________

	Yes	No
Do your gums bleed while brushing or flossing?		
Are your teeth sensitive to hot or cold liquids/foods?		
Are your teeth sensitive to sweet or sour liquids/foods?		
Do you feel pain to any of your teeth?		
Do you have any sores or lumps in or near your mouth?		
Have you had any head, neck, or jaw injuries?		
Have you ever experienced any of the following problems in your jaw?		
Clicking/popping		
Pain (joint, ear, side of face)		
Difficulty in opening or closing		
Difficulty in chewing		
Do you have frequent headaches?		
Do you clench or grind your teeth?		
Do you bite your lips or cheeks frequently		
Are you troubled with bad breath?		

	Yes	No
Have you noticed any loosening of your teeth?		
Does food tend to become caught between your teeth?		
Have you ever had periodontal treatment (gums)?		
Ever worn a bite plate or other appliance?		
Have you ever had any difficult extractions in the past?		
Have you ever had any prolonged bleeding following extractions?		
Do you wear dentures or partials?		
If yes, date of placement		
Have you ever oral hygiene instructions regarding the care of your teeth and gums?		
Have you had orthodontics/braces in the past?		
Would you be interested in teeth whitening?		
Have you had an unfavorable dental experience?		
Do you require pre-medication for dental visits?		

If you could do anything about your smile, what would you change? ______________________________

____

____

Appointments: A minimum charge will be made for failed or cancelled appointments without prior notification of 24 hours. Once an appointment is made, please remember this time with the hygienist or doctor has been reserved for just you.

Financial Policy: 1. For any crown and bridge appointments there will be a 5% CASH courtesy if paid when treatment begins. 2. Payment is expected when service are rendered. 3. Payment can be made in the form of Cash, Check, Debit or Credit Card. 4. Insurance: We will collect your estimated patient portion at the time of service 5. We try our best to estimate your insurance benefit portion, but if an unpaid balance is not paid in a timely manner, we can no longer file your insurance.

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release my information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners.
I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I agree to reimburse Springs Family Dentistry the fees of any collection agency, which may be based on a percentage at a maximum for 37% of any debt less than one(1) year old or a maximum of 50% of any debt over one(1) year old, including all costs, and expenses including reasonable attorney's fees, we incur in such collection efforts.

X______________________________ Date ______________

Signature of patient or parent if minor

Patient Information (Confidential)

Name ____ Date ________________
First Middle Last
Address ______________________City ______________________ State_______Zip ____________
Home Phone ______________________Work Phone ______________________
Cell phone ______________________Preferred day phone: Home Work Cell
Email address that you check daily – to be used for confirming appointments ______________________
Social Security # ________________ Birth Date ________________Occupation ________________
Check Appropriate Box Minor Single Married Divorced Widowed Separated
If college student, F.T./P.T., name of school ______________________City ______________State ______
Patient's or parent's employer______________________Work phone ______________
Business address ________________ City ________________State ________ Zip ______________
Spouse or parent's name ______________ Employer______________ Work phone ______________
Whom may we thank for referring you ______________________________________
Person to contact in case of an emergency ______________________ Phone______________

Responsible Party

Name of person responsible for this account ______________________Relationship to patient ______________
Address ______________________________Home Phone ______________
Driver's license # ______________________Birth date______________ Soc. security #______________
Employer ______________________________Work phone ______________
Is this person currently a patient in our office Yes No

Insurance Information

Name of insured______________________________Relationship to patient ______________
Birth date ______________________Soc. security # ______________________
Name of employer ______________________ Work phone ______________________
Employer address ______________________ City______________State __________ Zip____________
Insurance co. ______________________ Tel. # ______________Grp. # __________ Policy/I.D. # ______________
Ins. co. address ______________________ City______________State __________ Zip____________
How much is your deductible ______________ How much have you used___________Max annual benefit ______________

X ______________________________________ ______________________

Signature of patient or parent if minor Date