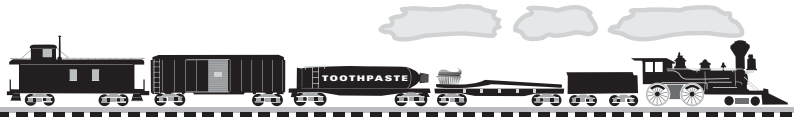

On the right track to good dental health

WELCOME: **WE ARE COMMITTED TO YOUR BEST DENTAL HEALTH AND STRIVE TO DELIVER QUALITY, GENTLE THOROUGH TREATMENT IN AN ATMOSPHERE FOSTERING TRUST AND UNDERSTANDING**

PATIENT INFORMATION

Today's Date: _____

Name: _____
LAST FIRST MI MR MRS MS DR

I prefer to be called: _____ ❑ Male ❑ Female

Birthdate: ___/___/___ Age: _____ SS#: _____

Home Address: _____
APT / CONDO #

_____
CITY STATE ZIP

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Home #: _____ Pager / Other #: _____

Work #: _____ Ext.: _____ DL #: _____

Employer:

Employer's Address _____
STREET

_____
CITY STATE ZIP

Who may we thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____
(Please Circle)

Last Visit Date: _____

Person responsible for account: _____

Work#: _____ Ext.: _____ Home#: _____

Billing Address: _____

Relationship: _____ SS#: _____

Employer: _____ DL# _____

In the event of an emergency, is there someone who we should contact?

Their Name: _____ Relationship: _____

WK#: _____ HM#: _____

Do you have a personal physician? Yes No

Physician's Name: _____

Phone: _____ Date of last visit _____

DENTAL INSURANCE

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy#): _____

Insured's Name: _____ Relationship _____

Insured's Birthday: ___/___/___ Insured's SS#: _____

Insured's Employer: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy#): _____

Insured's Name: _____ Relationship _____

Insured's Birthday: ___/___/___ Insured's SS#: _____

Insured's Employer: _____

PRIVACY REQUEST

For all correspondence and confirmation of appointments

I would like to be contacted by

❑ Home phone ❑ Work phone ❑ Cell phone

❑ No calls ❑ Other

❑ No correspondence with anyone other than me

DENTAL HISTORY

Why have you come to the dentist today? _____

_____

Have you ever had a serious/difficult problem associated with previous dental care?

_____

_____

Y	N	I have not seen a dentist for regular visits
Y	N	I find it difficult to swallow
Y	N	I have a sore in my mouth that does not heal
Y	N	I have pain or discomfort in my jaw joint (TMJ)
Y	N	My gums bleed when I brush
Y	N	I floss every day
Y	N	I have a painful tooth or area in my mouth
Y	N	I often have cold sores
Y	N	I like my smile

MEDICAL HISTORY

Your current physical health is *Good* *Fair* *Poor*

Are you currently under the care of a physician? *Yes* *No*

Please Explain: _____

Y N My physician has requested premedication for dental treatment
Y N I have Heart Valve Disease
Y N I have had Infective Endocarditis
Y N I have Congential Heart Disease, treated or untreated
Y N I have a Cardiac Transplant
Y N I have artifical bone or joint
Y N I take or have taken a medication for Osteoporosis
Y N Fosomax
Y N Boniva
Y N Actonel
Y N Zometa
Y N Aredia
Y N I take medication that makes my mouth dry
Y N I currently or recently have had chemotherapy
Y N I currently or recently have had radiation therapy

Have you ever had any of the following diseases or medical problems?

Y N Diabetes
Y N Hemophillia or abnormal bleeding
Y N Compromised Immune System
Y N HIV or AIDS
Y N Kidney function problems
Y N Epilepsy/Seizures/Fainting Spells
Y N Shingles
Y N Psychiatric problems that might interfere with dental treatment
Y N Lichen Planus
Y N I smoke
Y N I use chewing tobacco
Y N I have drug or alchol abuse problems
Y N I use cinnamon mouthwash, gum, or toothpaste
Y N Any other serious medical condition - please list below

_____

_____

ALLERGIES

Are you allergic to any of the following drugs?

Y N Penicillin Y N Tetracycline Y N Latex
Y N Aspirin Y N Dental Anesthetisc Y N Other
Y N Erythromycin Y N Codeine

Please list any other drugs that you are allergic to:

_____

_____

_____

_____

For Women:

Y N I am pregnant
Y N I am nursing
Y N I am taking birth control pills or hormone therapy

For doctor use only:

Medical History reviewed _____

Date: _____

Comments:

_____

_____

_____

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help.

I understand that the information that I give today concerning my Patient Information, Insurance Information, Medical History and Allergies is correcct to the best of my knowledge. I also understand that this information will be held in strictest confidence and it is my responsiblity to inform Dr. Bagaason of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need for diagnosis and treatment. I understand that account balances after 60 days will be charged 18% per annum or 1.5% per month.

_____ _____
Signature *Date*

Review

There are no changes to my Patient Information, Insurance Information or Medical History since I originally filled out this form:

_____ _____
Signature *Date*

There are no changes to my Patient Information, Insurance Information or Medical History since I originally filled out this form:

_____ _____
Signature *Date*