Welcome to Pacific Springs Dental

Patient Information (Confidential)

Date _____

Name _____ Birthdate _____ Home Phone_____

Address _____City_____ State_____ Zip _____

Social Security Number _____

Check where appropriate: ___ Minor ___Single ___Married ___Divorced ___Widowed ___ Separated

If student, name of school/college _____City_____ State _____ ___Full time ___ Part time

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 emergency_____ Phone_____

Responsible Party (Please fill out if different from above.)

Name of person responsible for this account_____ Relationship _____

Address_____Home phone_____

Birthdate_____ Employer_____ Work phone_____

Social Security Number _____

Insurance Information

Name of insured _____ Relationship_____

Birthdate _____ Social Security Number _____

Name of Employer _____ Work phone _____

Insurance Company _____ Group # _____

Policy/ID #_____

DO YOU HAVE ADDITIONAL INSURANCE? _____ Yes _____ No If yes, complete the following:

Name of insured _____ Relationship_____

Birthdate _____ Social Security Number _____

Name of Employer _____ Work phone _____

Insurance Company _____ Group # _____

Policy/ID #_____

Patient Medical History

Physician _____ Office phone_____ Date of last exam_____

Circle your response.

1. Are you under medical treatment now? …….. Yes No

2. Have you been hospitalized for surgery or a serious illness in the last 5 years? If yes, please explain Yes No
_____
_____

3. Are you taking any medication(s)? Yes No
If yes, what (medication(s) are you taking_____
_____

4. Have you taken bisphosphonates for cancer or osteoporosis? Yes No

5. Have you ever taken Phen-Fen/Redux? …….Yes No

6, Do you use tobacco? …….. Yes No

7. Do you use controlled substances? …… Yes No

8. Do you have or have you had any of the following:

	Yes	No		Yes	No
High blood pressure ……	Y	N	Heart attack ……..	Y	N
Asthma ……	Y	N	Rheumatic fever ……	Y	N
Diabetes ……	Y	N	Kidney disease ……	Y	N
AIDS or HIV infection ……	Y	N	Thyroid problem …….	Y	N
Heart disease …….	Y	N	Cardiac pacemaker …….	Y	N
Heart murmur …….	Y	N	Anemia …….	Y	N
Emphysema ……	Y	N	Cancer ……	Y	N
Joint replacement or implant ……	Y	N	Hepatitis/Jaundice ……	Y	N
Sexually transmitted disease ……	Y	N	Stomach troubles/ulcers ……..	Y	N
Stroke ……..	Y	N	Hay fever/allergies ……	Y	N
Radiation therapy ……..	Y	N	Glaucoma ……..	Y	N
Liver disease ……	Y	N	Mitral valve prolapse ……	Y	N

Any other conditions _____

9. Are you allergic to have you had any reactions to the following:

Local anesthetics (e.g. Novacain)……..	Yes	No
Penicillin or other antibiotics ……..	Yes	No
Barbiturates ……..	Yes	No
Sedatives ……..	Yes	No
Aspirin or ibuprofen ……	Yes	No
Any metals (e.g. nickel, mercury, etc.) ……	Yes	No
Latex rubber …….	Yes	No
Other (please list)_____	Yes	No

10. Are you wearing contact lenses? ……Yes No

11. Women only:
a) Are you pregnant or think you may be pregnant? Yes No
b) Are you nursing? ……...Yes No
c) Are you taking oral contraceptives? …… ..Yes No

Patient Dental History

Name of previous dentist and location _____Date of last exam _____

1. Do your gums bleed when brushing/flossing? Yes No
2. Are your teeth sensitive to hot or cold liquids? Yes No
3. Are your teeth sensitive to sweet/ sour foods? Yes No
4. Have you had any head, neck or jaw injuries? Yes No
5. Have you experienced any of the following problems In your jaw?
   - Clicking …… Yes No
   - Pain (joint, ear, side of face)…… Yes No
   - Difficulty in opening or closing…… Yes No
   - Difficulty in chewing …….. Yes No
6. Are you interested in bleaching your teeth? ….. Yes No
7. Do you clench or grind your teeth? …… Yes No
8. Have you ever had difficult extractions? …….. Yes No
9. Have you had prolonged bleeding following extractions? Yes No
10. Do you have sores or lumps in or near your mouth? Yes No
11. Have you received instruction regarding the care of your teeth and gums? …….. Yes No
12. Is there anything you would like to improve about your smile? ……..Yes No
    If yes, what would it be? _____

Authorization and release

I certify that I have read and understand the 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 any information including the diagnosis and 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.

_____

Signature of patient (or parent, if minor)