Family Dental Care (503) 644-1110

How did you hear about us? _____

Patient Name:_____ DOB:_____

Previous Dentist:_____ Last Exam:_____ Last Cleaning:_____

Dental History

Do you feel pain in any of your teeth? If so, where?_____
Do your gums bleed while brushing/flossing? YES or NO
Do you have pain in your (Circle) jaw joint / frequent headaches / history of TMJ?
Do you have sores or lumps in your mouth that you are concerned about? YES or NO
Have you ever had prolonged bleeding following a surgery or extraction? YES or NO
Have you ever had a bad dental experience? If yes, please explain_____

Medical History

Physician's Name:_____ Phone:_____ Date of last visit:_____

Have you stayed overnight in the hospital within the last 5 years? Explain:_____

_____

Do you have and **ALLERGIES** to medications? (circle)
PENICILLIN CODEINE VICODIN TETRACYCLINE E-MYCN ASPIRIN OTHER

_____

Are you taking any **MEDICATIONS**? Please list:

_____

_____

General Conditions (circle all that apply)

Arthritis / Rheumatism
Artificial Joint / Pin
Cancer / Tumor
Chemotherapy / Radiation
Diabetes
Epilepsy / Seizures
Fainting / Dizzy spells
Glaucoma
Hepatitis A / B / C
HIV or AIDS
Kidney disease
Liver disease
Neurological disorder
Psychological problem
Nervous / Anxious
Respiratory problems

Asthma
Allergies / Hives
Sinus trouble
Steroid use
Stroke
Thyroid disease
Tuberculosis
Ulcers / Stomach issues
Dietary Restrictions
Latex sensitive

HAVE YOU EVER USED:
Alcohol
Tobacco
IV Drugs
Other_____

BLOOD PROBLEMS:
Abnormal Bleeding
Anemia
Blood Transfusion (year)_____
Leukemia

HEART PROBLEMS:
Heart Murmur
Rheumatic fever
Angina / Chest Pain
Artificial valve / shunt
Heart Attack
Heart disease
High / Low blood pressure
Pacemaker

Anything else we should know about your health?_____

For women only: Are you pregnant? YES NO MAYBE How far along? _____ Are you using Birth control? Y / N

Dentist initial:_____ ASA:_____ Date:_____ Review:_____ Date:_____

THIS FORM MUST BE FULLY COMPLETED BEFORE SERVICES WILL BE PROVIDED.

In the case of an Emergency notify:_____ Relation:_____

Phone:_____ Alternate:_____

PATIENT INFORMATION

Patient Name:_____ Birth date:_____ Sex: M F

Social Security Number:_____ (Circle) Married / Single Spouse Name:_____

Address_____ Apt._____ City_____ State_____ Zip_____

Phone:_____ Alternate:_____ Work:_____

Employer:_____ Insurance Company:_____ ID Number:_____

INSURED PERSON / RESPONSIBLE PARTY / CO-SIGNER INFORMATION

Name:_____ Birth Date:_____ Relationship to patient:_____

Social Security Number:_____ Sex: M F (Circle) Married / Single

Address_____ Apt._____ City_____ State_____ Zip_____

Phone:_____ Alternate:_____ Work:_____

Employer:_____ Insurance Company:_____ ID Number:_____

Please list one personal reference (outside of your immediate family.)

Name:_____ Relationship to patient:_____

Address_____ Apt._____ City_____ State_____ Zip_____

Phone:_____ Alternate:_____

PLEASE READ THOROUGHLY BEFORE SIGNING.

I HAVE FILLED OUT THIS QUESTIONNAIRE COMPLETELY AND ACCURATELY TO THE BEST OF MY KNOWLEDGE; I HAVE INFORMED YOU OF ANY AND ALL MEDICAL CONDITIONS, PROBLEMS OR ALLERGIES OF WHICH I AM AWARE.

I understand that all crowns, bridges, dentures and partial dentures are custom work and the entire charge is incurred once the procedure has begun. I also understand that any remake of these procedures due to my failure to have them completed within the customary length of time may result in additional charges. I further realize the financial arrangements based on insurance payment are estimates based on normal ethical dental practices and available information concerning my benefits and that I am ultimately responsible for all charges.

I also agree to keep all of my appointments and to give at least *24 hours* notice if I am unable to make it. I have been informed of all risks involved with my dental treatment and anesthesia and I am hereby giving consent to have these services performed.

By signing below, I understand that you may request a credit report on me and any additional applicants. I hereby authorize all insurance or third party payers to make payment directly to the dentist for services rendered. IF A CHECK IS SENT TO ME DIRECTLY FROM THE INSURANCE COMPANY OR THIRD PARTY PAYER I AGREE TO SUBMIT THE CHECK TO YOUR OFFICE WITHIN FIVE (5) BUSINESS DAYS.

PATIENT / RESPONSIBLE PARTY SIGNATURE_____ **DATE**_____