PHANTASTIC DENTAL CARE

1 PATIENT INFORMATION

Date ______

Patient ______

Address ______

______
City State Zip

Sex: ☐ M ☐ F Age ______ Birthdate ______

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS# ______

Occupation ______

Employer ______

Employer Address ______

Employer Phone ______

Spouse's Name ______

Birthdate ______ SS# ______

Occupation ______

Spouse's Employer ______

Whom may we thank for referring you? ______

______

2 DENTAL INSURANCE

Primary Insurance Co: ______

Subscriber's Name: ______

Birth date: ______ SS# ______

Relationship to Patient: ______

Secondary Insurance Co: ______

Subscriber's Name: ______

Birth date: ______ SS# ______

Relationship to Patient: ______

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with ______ and assign directly to Dr. ______ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

______
Responsible Party Signature

______ ______
Relationship Date

3 PHONE NUMBERS

Home: ______ Cell: ______ Spouse's Cell: ______

Best time and place to reach you ______

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name ______ Relationship ______

Home Phone ______ Work Phone ______

4 DENTAL HISTORY

Reason for today's visit ______

______

Former Dentist ______

City/State ______

Date of last dental visit ______

Date of last dental X-rays ______

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Bad breath ☐ Yes ☐ No

Bleeding gums ☐ Yes ☐ No

Blisters on lips or mouth ☐ Yes ☐ No

Burning sensation on tongue ☐ Yes ☐ No

Chew on one side of mouth ☐ Yes ☐ No

Cigarette, pipe, or cigar smoking ☐ Yes ☐ No

Clicking or popping jaw ☐ Yes ☐ No

Dry mouth ☐ Yes ☐ No

Fingernail biting ☐ Yes ☐ No

Food collection between the teeth ☐ Yes ☐ No

Foreign objects ☐ Yes ☐ No

Grinding teeth ☐ Yes ☐ No

Gums swollen or tender ☐ Yes ☐ No

Jaw pain or tiredness ☐ Yes ☐ No

Lip or cheek biting ☐ Yes ☐ No

Loose teeth or broken fillings ☐ Yes ☐ No

Mouth breathing ☐ Yes ☐ No

Mouth pain, brushing ☐ Yes ☐ No

Orthodontic treatment ☐ Yes ☐ No

Pain around ear ☐ Yes ☐ No

Periodontal treatment ☐ Yes ☐ No

Sensitivity to cold ☐ Yes ☐ No

Sensitivity to heat ☐ Yes ☐ No

Sensitivity to sweets ☐ Yes ☐ No

Sensitivity when biting ☐ Yes ☐ No

Sores or growths in your mouth ☐ Yes ☐ No

How often do you floss? ______

How often do you brush? ______

5 HEALTH HISTORY

Physician's Name________________________ Date of last visit____________

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
AIDS	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fainting or dizziness	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Hepatitis Type________	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Skin Rash	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	HIV Positive	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No	Swelling of Feet or Ankles	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No	Tumor or growth on head or neck	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Do you wear contact lenses?	☐ Yes	☐ No	Women:			Venereal Disease	☐ Yes	☐ No
			Are you pregnant?	☐ Yes	☐ No	Weight Loss, unexplained	☐ Yes	☐ No
			Due date________					
			Are you nursing?	☐ Yes	☐ No			

MEDICATIONS

List medications you are currently taking:

____

____

Are you currently taking blood thinner? ☐ Yes ☐ No

Pharmacy Name________________________

Phone________________________

ALLERGIES

☐ Aspirin
☐ Local Anesthetic
☐ Barbiturates (Sleeping pills)
☐ Penicillin
☐ Codeine
☐ Sulfa
☐ Iodine
☐ Other____________
☐ Latex

____

6 UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions?________________________

Are you taking any new medications?__________ If so, what________________

Patient's Signature________________________ Date__________

Doctor's Signature________________________ Date__________

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions?________________________

Are you taking any new medications?__________ If so, what?________________

Patient's Signature________________________ Date__________

Doctor's Signature________________________ Date__________