Spectrum Dental Arts

THANK YOU FOR CHOOSING OUR DENTAL HEALTHCARE TEAM!

PATIENT INFORMATION (CONFIDENTIAL)

Name:_____ Soc Sec. #:_____Email address_____

Birthdate:_____ Home Phone #:_____ Work#:_____Cell#_____

Address: _____ City: _____State:_____ ZIP:_____

Check appropriate box: ☐ Minor ☐ Single ☐Married ☐Divorced ☐Widowed ☐Separated

If student, name of school:_____ City: _____State: _____ZIP:_____

Patient s or Parent s Employer:_____ Work Phone: _____

Employer 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

Name of person responsible for this account: _____ Relationship to patient: _____

Address: _____ Home phone:_____

Driver s license#: _____Birthdate: _____ Financial Institution: _____

Employer: _____ Soc. Sec.#: _____Work phone: _____

Is this person currently a patient in our office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer for payment in full at each appointment.
☐ Cash ☐ Personal check ☐ Credit Card ☐Visa ☐Master Card ☐I wish to discuss the office s payment policy.

INSURANCE INFORMTION

Name of insured: _____ Relationship to patient: _____

Birthdate: _____ Soc. Sec.#: _____ Date employed: _____

Name of employer: _____ Union or Local #: _____ Work phone: _____

Employer address: _____ City: _____ State: _____ ZIP: _____

Insurance Company: _____ Group#: _____ Policy/ID#: _____

Insurance co. address: _____ City: _____ Stat: _____ ZIP: _____

How much is deductible? _____ How much have you used? _____ Max annual benefit: _____

Do you have additional Insurance? ☐ Yes ☐ No **If YES, complete the following:**

Name of Insured: _____ Relationship to patient: _____

Birthdate: _____ Soc. Sec.#: _____ Date Employed: _____

Name of employer: _____ Union or Local #: _____ Work phone: _____

Employer address: _____ City: _____ State: _____ZIP:_____

Insurance company: _____ Group#: _____ Policy/ID#: _____

How Much is deductible? _____ How much have you used? _____ Max annual benefit: _____

OVER PLEASE

PATIENT MEDICAL HISTORY

Physician: _____ Office phone: _____ Date of last exam: _____

1. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High blood pressure?……	☐	☐	Heart disease? ……..…	☐	☐	Chest pains? ……..	☐	☐
Heart attack? …….....	☐	☐	Cardiac pacemaker? ……	☐	☐	Easily winded?……..…..	☐	☐
Rheumatic fever? ……...	☐	☐	Heart murmur? ……	☐	☐	Stroke? ……...	☐	☐
Swollen ankles? ……	☐	☐	Angina? ……..	☐	☐	Hay Fever / Allergies?…..	☐	☐
Fainting / seizures? ……	☐	☐	Frequently tired? ……	☐	☐	Tuberculosis? ……	☐	☐
Asthma? …….	☐	☐	Anemia? …….	☐	☐	Radiation therapy? ……	☐	☐
Low blood pressure? ……..	☐	☐	Emphysema? ……..	☐	☐	Glaucoma? ……	☐	☐
Epilepsy / convulsions? …….	☐	☐	Cancer?……	☐	☐	Recent weight loss?……	☐	☐
Leukemia? …….	☐	☐	Arthritis? …….	☐	☐	Liver Disease? ……..	☐	☐
Diabetes? ……..	☐	☐	Joint replacement or implant.	☐	☐	Heart trouble? ……	☐	☐
Kidney diseases? ……..	☐	☐	Hepatitis / Jaundice? ……	☐	☐	Respiratory Problems? …..	☐	☐
AIDS OR HIV infection? …….	☐	☐	Sexually transmitted disease?	☐	☐	Mitral Valve Prolapse? ….	☐	☐
Thyroid problem? …….	☐	☐	Stomach troubles / Ulcers? ..	☐	☐	Other? ……	☐	☐

	Yes	No
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years (If yes, please explain)? ……	☐	☐
3. Are you under medical treatment now? ……	☐	☐
4. Are you taking any medications) including non-prescription medicine? …….. If Yes, what medication (s) are you taking?	☐	☐
5. Have you ever taken Phen-Fen / Redux?……	☐	☐
6. Do you use tobacco? ……..	☐	☐
7. Do you use controlled substances? ……	☐	☐
8. Are you wearing contact lenses? ……	☐	☐
9. Have you ever been premedicated with antibiotics for your dental treatment? …….	☐	☐
10a. Are you pregnant or think you are pregnant? …….	☐	☐
10b. Are you breast feeding? …….	☐	☐
10c. Are you taking oral contraceptives? …….	☐	☐
11. Do you wear a cardiac pacemaker, or have you had heart surgery?……	☐	☐
12. Are you sensitive or allergic to any drugs?	☐	☐
Local anesthetics (eg. Novocaine)?…….	☐	☐
Penicillin or any other Antibiotic? ……...	☐	☐
Sulfa drugs? ……	☐	☐
Barbiturates? ……...	☐	☐
Sedatives? ……	☐	☐
Iodine? ……	☐	☐
Aspirin? ……	☐	☐
Any metals (eg. Nickel, mercury, etc,? ……	☐	☐
Latex Rubber? …….	☐	☐
Codeine? …….	☐	☐
Tetracycline? ……...	☐	☐
Other (please list)? …….	☐	☐
13. Do you have a disease, condition or problem not listed that you think we should know about? ……...	☐	☐

PATIENT DENTAL HISTORY

Previous dentist name:_____ Date of last exam: _____

1. Why are you here today? ☐Check up ☐ Cleaning ☐ Toothache ☐ Other _____
2. What treatment was performed last? _____
3. When were dental X-rays last taken? _____

	Yes	No
4. Was the last treatment completed? …….	☐	☐
5. Do your gums bleed while brushing or flossing? ……...	☐	☐
6. Are your teeth sensitive to hot or cold quicks/foods? …	☐	☐
7. Are your teeth sensitive to sweet or sour liquids/foods?.	☐	☐
8. Do you feel pain to any of your teeth? ……	☐	☐
9. Do you have any sores or lumps in or near your mouth?.	☐	☐
10. Have you had any head, neck or jaw injuries? ……...	☐	☐
11. Do you have frequent headaches? …….	☐	☐
12. Do you clench or grind your teeth? ……...	☐	☐
13. Do you bite your lips or cheeks frequently? ……..	☐	☐

	Yes	No
15. Have you ever experienced any of the following problems in your jaw?:		
Clicking ……	☐	☐
Pain (Joint, ear, side of face) ……	☐	☐
Difficulty in opening and closing ……	☐	☐
Difficulty in chewing ……..	☐	☐
16. Have you ever had any prolonged bleeding followed by extractions? …….	☐	☐
17. Have you had any orthodontic treatment?…	☐	☐
18. Do you wear dentures or partials? ……... If yes, date of placement _____	☐	☐
19. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?…	☐	☐
20. Do you like your smile? ……	☐	☐

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 any 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 payers 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 service. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____
Initials

Consent

I hereby authorize the dentist(s) assisted by other dentists and/or dental auxiliaries of his/her choice, to perform upon myself or my child needed x-rays, study models, photographs or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis. I am aware that most frequently used materials in restorative dentistry are amalgom (alloy mercury) composite resin glass onomer cement, resin-lonomer cement porcelain (ceramic). Porcelain (fused to metal), Gold alloys (noble) and nickel or cobalt chrome (base-metal) alloys. Each material has its own advantages and disadvantages, benefits and risks. I have had the opportunity to review the dental material fact sheet dated May 2004.

x _____ _____ x _____ _____
Signature of patient (or parent if minor) Date Signature of Doctor Date

UPDATE HISTORY (6mo & 12mo update)

x _____ _____ x _____ _____
Signature of patient (or parent if minor) Date Signature of Doctor Date

x _____ _____ x _____ _____
Signature of patient (or parent if minor) Date Signature of Doctor Date