

Wellness. Comfort. Care.

WELCOME

Our goal is to give you the most professional and up to date care available in a relaxing and friendly environment.

If there is anything we can do to make your experience better please let us know.

PATIENT INFORMATION

Patient name _____ Nickname _____ Date _____

Address _____

City _____ State _____ Zip _____

Home Phone (____) _____ Work Phone (____) _____

Cell Phone (____) _____ Email _____

Best daytime contact number (____) _____

Employer _____ Occupation _____

Employer Address _____ City _____ State _____ Zip _____

Social Security Number _____ Male _____ Female _____ Date of Birth _____

____ Single ____ Married: Spouse/ Partner's Name _____ Children _____

In Case Of Emergency Contact _____

Relationship _____ Phone _____

Who may we thank for referring you? _____

INSURANCE INFORMATION

Insurance Company _____

Complete Insurance Address _____

Insurance Phone Number (____) _____ Group Number _____

Do you have any secondary insurance? _____

Name of insured if other than yourself? _____

Relationship _____ Date of Birth _____ Social Security Number _____

Employer _____

I, the undersigned, (or my dependent), certify that I have the insurance coverage above and assign directly to Dr. Stephenson all dental insurance benefits. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges whether or not paid by insurance.

Responsible Party Signature _____

Relationship _____ Date _____

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HEALTH HISTORY

NAME _____ DATE: _____

Are you in good health now? _____ Are you under the care of a physician? _____

Physicians name _____ Phone Number (____) _____

Date of last physical _____ Abnormal findings? _____

Describe _____

Have you seen a dermatologist? _____ How often? _____

Please list any hospitalizations and surgeries you have had _____

Any complications? _____ Have you ever had a blood transfusion? _____

(Women) Are you pregnant? _____ Nursing? _____ (Women) Do you see a GYN yearly? _____

Would you like any specialist referrals? _____

CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Artificial joints / metal | <input type="checkbox"/> Mitral valve prolapse |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis / Jaundice | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Persistent cough |
| <input type="checkbox"/> Ulcers / Esophageal reflux | <input type="checkbox"/> Artificial valves | <input type="checkbox"/> Stroke | <input type="checkbox"/> Upper or Lower GI disease |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Epilepsy / convulsions | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Dizziness / Fainting | <input type="checkbox"/> Frequent / Pain – urinating | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Endocrine disease | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Arthritis / Rheumatism | <input type="checkbox"/> Cancer /Tumors /Radiation | <input type="checkbox"/> Tire easily / Weakness |
| <input type="checkbox"/> Marked weight change | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Back problems | <input type="checkbox"/> Psychiatric care |

Is there anything else about your health we should be aware of? _____

Do you, or have you used any tobacco products? _____ How much? _____ For how long? _____

Do you have more than 2 alcoholic drinks a day? _____ Have you used addictive or controlled substances? _____

Have you used Fenphen? _____ Have you been evaluated by a cardiologist? _____

Do you have any health care providers you feel are exceptional that we might use for referrals? _____

LIST ANY MEDICATIONS YOU ARE TAKING:

_____ Aspirin _____ Ibuprofen _____ Tylenol _____

Pharmacy _____ Barbiturates _____ Codeine _____ Sulfa _____

Phone Number (____) _____ Local anesthetics _____ Penicillin _____ Other _____

ALLERGIES

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of the staff responsible for errors or omissions I may have made.

Signature _____ Date _____

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DENTAL HISTORY

The more we know about you the better we will be able to serve you.

NAME _____ DATE _____

Reason for today's visit _____

Former Dentist _____ Phone Number (____) _____

Why you left _____ What are you looking for in a dentist _____

Date of last dental cleaning _____ Date of last X-ray _____

How do you take care of your teeth? _____

CHECK IF YOU ARE EXPERIENCING ANY OF THE FOLLOWING:

- | | |
|--|--|
| <input type="checkbox"/> Sensitivity to hot, cold, sweet, or biting pain | <input type="checkbox"/> Bad breath |
| <input type="checkbox"/> Sensitivity at the gum line | <input type="checkbox"/> Mouth sores |
| <input type="checkbox"/> Bleeding, tenderness, or swelling in your gums | <input type="checkbox"/> Broken tooth |
| <input type="checkbox"/> Grinding your teeth or clenching your jaw | <input type="checkbox"/> Loose teeth |
| <input type="checkbox"/> Food catching between your teeth | <input type="checkbox"/> Missing teeth |
| <input type="checkbox"/> Tired or sore jaw especially in the morning | |
- Do you hit some teeth before others when you bite
- Have you fractured a tooth?
- Have you had braces?
- Have you had your wisdom teeth removed? Any complications? _____
- Have you had periodontal / gum treatment before?
- Would you like to discuss tooth replacement?

How do you feel about your smile? _____

Does your dental condition affect:

- | | | |
|--|--|--------------------------------|
| <input type="checkbox"/> Decreased self confidence | <input type="checkbox"/> Discomfort in social situations | |
| <input type="checkbox"/> Diet changes / requirements | <input type="checkbox"/> Physical discomfort | |
| <input type="checkbox"/> Your personal life | <input type="checkbox"/> Your general health | <input type="checkbox"/> Other |

Are you concerned with any of the following:

- | | | |
|--|--|--------------------------------|
| <input type="checkbox"/> Old fillings wearing out | <input type="checkbox"/> Facial appearance, lip support, premature aging | |
| <input type="checkbox"/> Preventing gum disease | <input type="checkbox"/> Shortened teeth from grinding | |
| <input type="checkbox"/> Yellowing, discoloring of teeth | <input type="checkbox"/> Loss of function, loss of teeth | <input type="checkbox"/> Other |
| <input type="checkbox"/> Un-natural looking dental work | | |

What can we do to make your dental experience the best? _____
