

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:

- Sensitivity to hot, cold, sweet, or biting pain
- Sensitivity at the gum line
- Bleeding, tenderness, or swelling in your gums
- Grinding your teeth or clenching your jaw
- Food catching between your teeth
- Tired or sore jaw especially in the morning
- Bad breath
- Mouth sores
- Broken tooth
- Loose teeth
- Missing teeth
- 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:

- Decreased self confidence
- Diet changes / requirements
- Your personal life
- Discomfort in social situations
- Physical discomfort
- Your general health
- Other

Are you concerned with any of the following:

- Old fillings wearing out
- Preventing gum disease
- Yellowing, discoloring of teeth
- Un-natural looking dental work
- Facial appearance, lip support, premature aging
- Shortened teeth from grinding
- Loss of function, loss of teeth
- Other

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