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 _____

Wellness. Comfort. Care.

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:

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

_____

Pharmacy _____

Phone Number (___) _____

ALLERGIES

Aspirin _____ Ibuprofen _____ Tylenol _____

Barbiturates _____ Codeine _____ Sulfa _____

Local anesthetics _____ Penicillin _____ Other _____

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 _____

Wellness. Comfort. Care.

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 of 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? _____

_____