

WELCOME TO BLUFF CREEK DENTAL

PATIENT INFORMATION...

Date _____

Mr. Mrs. Ms. First Name _____ M.I. _____ Last Name _____ Nickname _____
Sex: Male Female Birth Date _____ Age _____ Soc. Sec. # _____ E-mail _____
Street _____ City _____ State _____ Zip _____
Home Tel.(_____) _____ Cell.(_____) _____
Referred By _____ Has a family member ever been a patient of our practice? Yes No
Employer _____ Bus. Tel.(_____) _____
In case of emergency, please contact _____ Tel. (_____) _____ Relation _____

Student: Full Time Part Time Not School Name and Address _____
Marital Status: Married Divorced Widow Single _____

INSURANCE INFORMATION...

Name on Account: Self Spouse Father Mother Other _____
PRIMARY Dental Insurance: Insurance Company Name _____
Group # _____ ID / Social Security # _____ Employer _____
If Spouse is the policy holder: Spouse's Name _____ Spouse's Birth Date _____
Spouse's Social Security # _____ Spouse's Employer _____
SECONDARY Dental Insurance: Insurance Company Name _____
Group # _____ ID / Social Security # _____ Employer _____
If Spouse is the policy holder: Spouse's Name _____ Spouse's Birth Date _____
Spouse's Social Security # _____ Spouse's Employer _____

DENTAL INFORMATION...

Why have you made this dental appointment? _____ Are you in pain? Yes No, For How Long? _____
Why did you leave the office of your previous dentist? _____
Last dental exam _____ Last dental x-rays _____ Times a day you brush? _____ Times a week you floss? _____
How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best) _____ Would you like whiter teeth? Yes No
What type of toothbrush bristles do you use? Soft Medium Hard

Are any teeth sensitive to cold air, ice water, sweets, or brushing? Yes No
Are any teeth sore when you chew or drink? Yes No
How much soda do you drink each day?
Do you have sensitive, tender, or swollen gums? Yes No
Do you ever have canker sores or cold sores? Yes No
Is your breath as fresh as it could be? Yes No
Do you have any sores or lumps in or near your mouth? Yes No
Have you ever seen a periodontist? Yes No

TMJ

Are you aware of clenching or grinding your teeth? Yes No
Do you have frequent headaches? Yes No
Do you wake up with, or experience tired / painful jaw joints or muscles? Yes No
Have you had any head, neck, or jaw injuries? Yes No

Obstacles I see to having excellent dental care for myself: (If you select more than one of the following please number them in order of significance with #1 being most significant)

____ I see no obstacles ____ Time away from work or other obligations ____ Fear of pain, surgery, or injections ____ The cost of treatment
____ Fear because of past dental experiences ____ Other _____

MEDICAL HISTORY...

Patient Name _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now? Yes No If yes, please explain _____
- Have you ever been hospitalized, or had a major operation? Yes No If yes, please explain _____
- Have you ever had a serious head or neck injury? Yes No If yes, please explain _____
- Are you taking any medications, pills, or drugs? Yes No If yes, please explain _____
- Do you take, or have you taken, Phen-Fen or Redux? Yes No _____
- Do you take, or have you taken, Fosamax, Boniva, Actonel, or any Bisphosphonate medication? Yes No _____
- Are you on a special diet? Yes No _____
- Do you use tobacco? Yes No _____
- Do you use controlled substances? Yes No _____

WOMEN: ARE YOU

Pregnant / Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

- Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Sulfa Drugs
- Other; if yes, please explain _____

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING? (CHECK IF TRUE)

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> AIDS / HIV positive | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Alzheimer's disease | <input type="checkbox"/> Drug addiction | <input type="checkbox"/> Herpes | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Easily winded | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Epilepsy or seizures | <input type="checkbox"/> Hives or rash | <input type="checkbox"/> Sickle cell disease |
| <input type="checkbox"/> Arthritis / Gout | <input type="checkbox"/> Excessive bleeding | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Sinus trouble |
| <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Spina bifida |
| <input type="checkbox"/> Artificial joint | <input type="checkbox"/> Fainting spells / Dizziness | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Stomach / Intestinal disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Frequent cough | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood disorder | <input type="checkbox"/> Frequent diarrhea | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Swelling of limbs |
| <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Breathing problem | <input type="checkbox"/> Genital herpes | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tumors or growths |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart attack / Failure | <input type="checkbox"/> Pain in jaw joints | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Chest pains | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Parathyroid disease | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Cold sores / Fever blisters | <input type="checkbox"/> Heart pace maker | <input type="checkbox"/> Psychiatric care | <input type="checkbox"/> Yellow jaundice |
| <input type="checkbox"/> Congenital heart disorder | <input type="checkbox"/> Heart trouble / Disease | <input type="checkbox"/> Radiation treatments | |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Recent weight loss | |
| <input type="checkbox"/> Cortisone medicine | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Renal dialysis | |

Have you ever had any serious illness not listed above? Yes No; if yes, please explain _____

Comments _____

I certify the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

X _____ X _____ X _____
Signature of patient (Parent or Guardian if Minor) Reviewed by Date

CONSENT FOR TREATMENT: The undersigned hereby authorizes Dr. Schold to take X-rays, impression for diagnostic casts, photographs or any other diagnostic procedures deemed necessary to make a thorough diagnosis of the patients' oral health. I also authorize Dr. Schold to perform dental treatment, to use any and all dental materials, and to administer medications and therapy which may be indicated.

X _____ X _____ X _____ X _____
Signature of patient Parent or Responsible Party Relationship Date

CONSENT TO BE PHOTOGRAPHED: As Dr. Schold is committed to furthering the quality of dental education through teaching and writing, I authorize Dr. Schold to take or record slides, photographs, digital images or videos of the patient for the purpose of treatment planning, teaching, publication, or research.

X _____ X _____ X _____ X _____
Signature of patient Parent or Responsible Party Relationship Date

FINANCIAL ARRANGEMENTS: We believe in the importance of quality dental care, and strive to provide the best dental treatment possible. We understand the financial limitations that can influence your choice or care. Please remember, that you are fully responsible for the portion of your treatment not covered by your insurance company.

X _____ X _____ X _____ X _____
Signature of patient Parent or Responsible Party Relationship Date

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

X _____ X _____
Signature of patient (Parent or Guardian if minor) Date