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 primary 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 Bisphophonate 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)*

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

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 _____ **Signature of patient** *(Parent or Guardian if Minor)* X _____ **Reviewed by** X _____ **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 _____ **Signature of patient** X _____ **Parent or Responsible Party** X _____ **Relationship** X _____ **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 _____ **Signature of patient** X _____ **Parent or Responsible Party** X _____ **Relationship** X _____ **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 _____ **Signature of patient** X _____ **Parent or Responsible Party** X _____ **Relationship** X _____ **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 _____ **Signature of patient** *(Parent or Guardian if minor)* X _____ **Date**