

Welcome to Dearborn Family Dentistry

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. So that we can serve you better, please complete both sides of this new patient history form.

PATIENT INFORMATION

Patient's Name _____ Today's Date _____
How do you wish to be addressed? _____
Birthdate _____ Social Security # _____ Sex Female Male Other _____
Marital status: Married Widowed Single Minor Separated Divorced Partnered for _____ years
Home Phone (____) _____ Cell Phone (____) _____ E-mail _____
Would you like to receive Email reminders? Yes/No Text Message reminders? Yes/No
Address _____ City _____ State _____ Zip _____
If patient is a minor, please give parent's or guardian's name _____
Emergency contact _____ Phone number _____
Whom may we thank for referring you? _____

RESPONSIBLE PARTY/BILLING INFORMATION

Name _____ Relationship to patient _____
Address _____ City _____ State _____ Zip _____
Mailing Address (if different than above) _____
How long at this address _____ Home Phone (____) _____ Work Phone (____) _____ Ext _____
Previous address (if less than 3 years) _____ How long at this address? _____
Social Security # _____ Birthdate _____
Employer _____ Occupation _____ No. Years Employed _____
Spouse's Name _____ Birthdate _____ Social Security # _____
Employer _____ Occupation _____ Years Employed _____ Work Phone _____

INSURANCE INFORMATION

Name of insured _____ Birthdate _____ Social Security # _____
Insurance Company _____ Group No. _____ I.D. # _____
Insurance Company Address _____
Employer _____ Work Phone (____) _____
Do you have dual coverage? _____ Yes _____ No If yes, please fill in the following:
Name of insured _____ Birthdate _____ Social Security # _____
Insurance Company _____ Group No. _____ I.D. # _____
Insurance Company Address _____
Employer _____ Work Phone (____) _____

CONSENT FOR TREATMENT

I hereby authorize Mount Angel Dental to administer any treatment and to administer such x-rays, anesthetic, and to perform such dental procedure as may be deemed necessary or advisable in the diagnosis and treatment of my dental condition. I authorize information to be released relating to any dental claims. I realize that I am ultimately responsible for all costs of dental treatment. I understand the use of anesthetic embodies a certain risk. I hereby authorize my insurance benefits to be paid directly to Mount Angel Dental.

Date _____ Signature (patient or parent/guardian for minor) _____

MEDICAL HISTORY

Patient's Name _____

Physician's Name _____

Name of the Practice they are located at _____

Phone Number (____) _____ Date of last visit _____

Have you been hospitalized in the last 2 years? _____ For? _____

(Women) are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Please list all medication and drugs you are taking _____

Have you ever had an adverse reaction or allergies to any medication or substance? (Please circle)

Aspirin	Valium	Sulfa Drugs	Penicillin	Novocain	Nitrous Oxide
Codeine	Iodine	Tetracycline	Erythromycin	Xylocaine	Latex Other _____

Check (✓) if you have had any of the following:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> Heart Valve | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Cough up Blood | or | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Artificial Joints, Pins | <input type="checkbox"/> Diabetes | Pacemaker | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Dizziness or Fainting | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Drug/Alcohol | <input type="checkbox"/> Herpes | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood Disease | Addiction | <input type="checkbox"/> Hepatitis (type:) | <input type="checkbox"/> Swelling of |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> High / Low | Feet or Ankles |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Emphysema | Blood Pressure | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> HIV – AIDs - ARC | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Frequent Thirst | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Tonsilitis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tumor or Growth |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Headaches | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Ulcer or |
| <input type="checkbox"/> Congenital | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Lung Disease | G.I. Problems |
| Heart Problems | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Venereal Disease |
| | | <input type="checkbox"/> Psychiatric Care | |

Do you have any conditions or problems not listed above which we should know about? _____

Please Explain _____

DENTAL HISTORY

What are your present dental concerns? _____

When did you last see a dentist? _____ When did you last have a dental X-ray? _____

Have you avoided regular dental care? ___ Yes ___ No Why? _____

Do you feel you have active decay? ___ Yes ___ No Do you feel you have gum diseases? ___ Yes ___ No

Have you ever had any periodontal (gum) treatments? ___ Yes ___ No

How often do you brush? _____ Floss? _____ Use other cleaning aids? _____

Are you happy with the appearance of your teeth? ___ Yes ___ No

Would you like your teeth to be whiter? ___ Yes ___ No

What are your dental expectations? _____

Previous dentist? _____ Name of Practice _____

City _____ State _____ Phone Number (____) _____

Would you like us to request your records from your pervious dentist? ___ Yes ___ No