

Welcome

Thank you for selecting our dental health care team! We will strive to provide you with the best possible dental care. To help us meet all of your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us, we will be happy to help.

Patient Information

Date _____

Name _____ Birth date _____ Soc. Sec. # _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ E-mail address _____

Please check appropriate space: Minor Single Married Divorced Widowed Separated

Employer _____ Work Phone _____ Ext. _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

If Patient is a Student, Name of School/College _____ City _____ St. _____

Who referred you or how did you find about this office? _____

Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ E-mail address _____

Driver's License # _____ Birthdate _____ Soc. Sec. # _____

Employer _____ Work Phone _____ Ext. _____

Dental Insurance Information

Name of Subscriber _____ Birthdate _____ Soc. Sec. # _____

Employer _____ Work Phone _____

Insurance Company _____ Group # _____ Ins. Co. Phone # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? YES NO IF YES, COMPLETE THE FOLLOWING

Name of Subscriber _____ Birthdate _____ Soc. Sec. # _____

Employer _____ Work Phone _____

Insurance Company _____ Group# _____ Ins. Co. Phone # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Over Please

Patient Medical History **Name** _____ **Male** ___ **Female** ___

Medical Doctor _____ **Office Phone** _____ **Date of Last Exam** _____

Are you under medical treatment now?	Yes	No	Are you allergic to any of the following?		
Have you ever been hospitalized?	Yes	No	Local Anesthetics (i.e., Novocain)	Yes	No
Do you smoke or use tobacco in any other form?	Yes	No	Penicillin	Yes	No
Do you use alcohol?	Yes	No	Sulfa Drugs	Yes	No
Do you use cocaine or any other drugs?	Yes	No	Aspirin	Yes	No
Do you wear contact lenses?	Yes	No	Codeine	Yes	No
Are you or have you taken Bisphosphonates?	Yes	No	Latex	Yes	No
Which one: Aredia, Zometa, Fosamax, Actonel, Boniva or Skelid.			Other Drugs _____	Yes	No

List ALL medications, prescription or over-the-counter, that you are taking. _____

Are you pregnant? Yes No Are you nursing? Yes No
Are you taking birth control pills? Yes No

Do you have or have you had any of the following? Circle One

Sight or Hearing Impaired	Y	N	Glaucoma	Y	N	Drug/Alcohol Abuse	Y	N
High Blood Pressure	Y	N	Heart Attack	Y	N	Liver Disease	Y	N
Low Blood Pressure	Y	N	Heart Murmur	Y	N	Diabetes	Y	N
Rheumatic Fever	Y	N	Mitral Valve Prolapse	Y	N	Hepatitis	Y	N
Swollen Ankles	Y	N	Heart Disease	Y	N	Sexually Transmitted Disease	Y	N
Kidney Disease	Y	N	Cardiac Pacemaker	Y	N	AIDS or HIV Infection	Y	N
Epilepsy, Seizures or Convulsions	Y	N	Angina or Chest Pain	Y	N	Thyroid Problems	Y	N
Asthma	Y	N	Stroke	Y	N	Cancer	Y	N
Emphysema	Y	N	Acid Reflux	Y	N	Radiation Therapy in the Head or Neck Region	Y	N
Respiratory Problems	Y	N	Anemia	Y	N	Chemotherapy	Y	N
Tuberculosis	Y	N	Bleeding Problems	Y	N	Weight Loss or Gain	Y	N
Hay Fever/Allergies	Y	N	Leukemia	Y	N	Frequently Tired	Y	N
Mental Health Treatment	Y	N	Joint Replacement/Implant	Y	N	Easily Winded	Y	N
Osteoporosis	Y	N	Stomach Trouble/Ulcers	Y	N	Arthritis	Y	N
			Organ Transplant	Y	N			

Any Other Illnesses: _____

Patient Dental History

Previous Dentist _____ **Office Phone** _____ **Date of Last Visit** _____

Do your gums bleed while brushing or flossing?	Y	N	Do you clench or grind your teeth?	Y	N
Are your teeth sensitive to hot, cold or sweet liquids/foods?	Y	N	Have you had periodontal disease or periodontal surgery?	Y	N
Do you have any sores or lumps in or near your mouth?	Y	N	Have you ever had orthodontic treatment?	Y	N
Have you had any head, neck or jaw injuries?	Y	N			
Have you ever experienced any of the following problems in your jaws?			Do you have well water?	Y	N
Clicking or popping	Y	N			
Pain in your joint, ear or side of face	Y	N			
Difficulty opening, closing or chewing	Y	N			

Authorization / HIPAA / Consent to Photograph

I have read and understand the above information and have answered the questions accurately to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health.

Notice of Privacy Practices: By signing this consent, I am giving permission to use my protected health information to carry out treatment, payment activities and health care operations.

I authorize Dr. Devries to provide dental services, prescribe, dispense and/or administer any drugs, medicaments, antibiotics, and local anesthetics that he deems necessary or appropriate in my care.

I consent to have photos taken of my teeth to be used for my dental records, education and training.

_____ Date _____

Signature of patient or parent of minor