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
Have you ever been hospitalized?	Yes	No
Do you smoke or use tobacco in any other form?	Yes	No
Do you use alcohol?	Yes	No
Do you use cocaine or any other drugs?	Yes	No
Do you wear contact lenses?	Yes	No
Are you or have you taken Bisphosphonates?	Yes	No

Which one: Aredia, Zometa, Fosamax, Actonel, Boniva or Skelid.

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

____

Are you allergic to any of the following?

Local Anesthetics (i.e., Novocain)	Yes	No
Penicillin	Yes	No
Sulfa Drugs	Yes	No
Aspirin	Yes	No
Codeine	Yes	No
Latex	Yes	No
Other Drugs ________________	Yes	No

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
		Stroke	Y N	Cancer	Y N
Asthma	Y N	Acid Reflux	Y N	Radiation Therapy in the Head or Neck Region	Y N
Emphysema	Y N	Anemia	Y N		
Respiratory Problems	Y N	Bleeding Problems	Y N	Chemotherapy	Y N
Tuberculosis	Y N	Leukemia	Y N	Weight Loss or Gain	Y N
Hay Fever/Allergies	Y N	Joint Replacement/Implant	Y N	Frequently Tired	Y N
Mental Health Treatment	Y N	Stomach Trouble/Ulcers	Y N	Easily Winded	Y N
Osteoporosis	Y N	Organ Transplant	Y N	Arthritis	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
Are your teeth sensitive to hot, cold or sweet liquids/foods?	Y N
Do you have any sores or lumps in or near your mouth?	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?

Clicking or popping	Y N
Pain in your joint, ear or side of face	Y N
Difficulty opening, closing or chewing	Y N

Do you clench or grind your teeth?	Y N
Have you had periodontal disease or periodontal surgery?	Y N
Have you ever had orthodontic treatment?	Y N
Do you have well water?	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