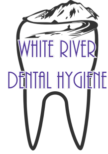

ABOUT YOU

Today's Date: ____/____/_____

If patient is a minor - Parent/Guardian Name:_________________DOB__________

Patient Name:_______________________
First Middle Initial Last
Nickname/Go by:_______________________
Date of Birth: ____/____/____ Age: _____
Social Security #:______________________
Check one:___Child ___Single __Married __Other
Address:_____________________________
City: _____________ State: ____ Zip: ____
Email address:_______________________
Home Phone:(_____) _________________
Cell Phone:(_____) __________________
Employer:___________________________
Occupation:_________________________
When and where are the best times to reach you?
____
Whom may we thank for referring you here?
____
Other family members seen by us?
____
____
____
Name of person who lives nearby we should notify in the event of an emergency:
____
Relationship:_________________________
Cell Phone: (_____) __________________
Other Phone: (____)___________________
Why have you come to the office today?
____
____

DENTAL

Are you currently in pain? ____Yes_____No
Previous Dentist/Hygienist:
____
Date of last visit:_______________________
Your current dental health is?
_____Good _____ Fair _____Poor
Do you like your smile? ____Yes _____No
Do your gums bleed? _____Yes _____No
How many times a day do you brush?_____
How many times a week do you floss?____
What type of water do you drink?
___City water ___Well water ___Bottled
___Filtered water

MEDICAL

Physician's Name:____________________
Phone: (____) ______________________
Date of last visit:_____________________

Have you had any serious illnesses or operations? ______Yes ______No
Are you currently under a physician's care?
______Yes ______No
If yes, please explain:_________________
____
Do you use tobacco products?__Yes __No
Do you vape? ___Yes ___No
How long? _________How often? _______
Please list all medications being taken and what the medication is for: _____________
____

For Women:

Are you taking birth control pills? ___Yes ___No

Are you pregnant? ___Yes ___No

If "Yes," what week? ____________________

Are you nursing? ___Yes ___No

Do you have a history of the following?

Yes No

___ ___ Artificial Bone/Joints, explain ________________________

___ ___ Do you normally take Antibiotics/Premedication prior to dental treatment?

___ ___ Artificial Valves

___ ___ Asthma

___ ___ Arthritis

___ ___ Autism/Asperger's

___ ___ Bisphosphonates

___ ___ Blood Transfusion

___ ___ Cancer/Chemotherapy, explain__________________

___ ___ Congenital Heart Defect

___ ___ Diabetes, what type_______

___ ___ Difficulty Breathing

___ ___ Drug/Alcohol Abuse

___ ___ Emphysema

___ ___ Endocarditis

___ ___ Epilepsy/Seizures

___ ___ Fever Blisters/Cold Sores

___ ___ Heart Attack, when?_______

___ ___ Stroke, when? ___________

___ ___ Mitral Valve Prolapse

___ ___ Taking blood thinners

___ ___ Pacemaker, when placed?__

___ ___ Heart Murmur

___ ___ Hemophilia/Abnormal bleeding

___ ___ Hepatitis B, C or D, what type? _________

___ ___ High or Low Blood Pressure

___ ___ HIV/AIDS

___ ___ Sinus Problems

___ ___ Ulcers/Colitis

___ ___ STD, Type_______________

___ ___ Tuberculosis

___ ___ Thyroid-explain___________

___ ___ Other____________________

Are you allergic to any of the following?

Yes No

___ ___ Aspirin

___ ___ Codeine

___ ___ Penicillin

___ ___ Latex

___ ___ Erythromycin

___ ___ Other___________________

CONSENT FOR

To the best of my knowledge, all the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the hygienist at the next appointment.

___ I understand that I am being seen by a licensed Colorado Dental Hygienist. I understand it is recommended that I see a licensed Dentist for dental exams yearly and that I am responsible for obtaining those exams.

___ I understand that White River Dental Hygiene, PLLC will have my radiographs viewed and evaluated by a licensed dentist.

___ I understand that communication may be done via e-mail and that it may not be encrypted. (Appointment reminders, x-rays, treatment notes, etc.) **Things like social security number and account information will not be shared, unless with an insurance company, which is encrypted.**

___ Payment is solely the responsibility of the patient or responsible party. We will gladly bill insurance as a service to you, but any nonpayment or partial payment is then the patient's responsibility. Non-payment may result in turning over your account to a collections agency.

I have read the above conditions of treatment and payment and I agree to their content.

Print Name:________________________

Signature of patient or Guardian:

____

Date:______________________________