ABOUT YOU

Today’s Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_

First Middle Last

I prefer to be called: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_\_ Age: \_\_\_\_\_\_\_

Check one: \_\_Single \_\_Married \_\_Widowed \_\_Divorced

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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 HISTORY

Are you currently in pain? \_\_\_\_Yes \_\_\_\_\_No

Previous Dentist/Hygienist: ­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a serious problem associated with any dental treatment? \_\_\_Yes \_\_\_No

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? \_\_\_\_\_\_\_

Why type of water do you drink? \_\_\_City water

\_\_\_Well water \_\_\_Bottled water \_\_\_Filtered water

MEDICAL HISTORY

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

How long? \_\_\_\_\_\_\_\_\_\_\_\_ How often? \_\_\_\_\_\_\_

Please list all medications being taken:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check whether you have ever had any of the following?

For Women:

Are you taking birth control pills? \_\_\_Yes \_\_\_No

Are you pregnant? \_\_\_Yes \_\_\_No

If “Yes,” what week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you nursing? \_\_\_Yes \_\_\_No

Yes No

\_\_\_ \_\_\_ Artificial Bone/Joints

\_\_\_ \_\_\_ 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, what type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ \_\_\_ High/Low Blood Pressure, circle one

\_\_\_ \_\_\_ HIV/AIDS

\_\_\_ \_\_\_ Sinus Problems

\_\_\_ \_\_\_ Ulcers/Colitis

\_\_\_ \_\_\_ Sexually transmitted disease

\_\_\_ \_\_\_ Tuberculosis

\_\_\_ \_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any serious medical problems you’ve ever had: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you allergic to any of the following?

Yes No

\_\_\_ \_\_\_ Aspirin

\_\_\_ \_\_\_ Codeine

\_\_\_ \_\_\_ Penicillin

\_\_\_ \_\_\_ Latex

\_\_\_ \_\_\_ Erythromycin

\_\_\_ \_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CONSENT FOR SERVICES

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. (Appointments 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.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Signature of patient, Date

Parent or guardian