

# Raleigh Park Dental Care

## ABOUT YOU

Today's Date: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

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

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

Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ SS#: \_\_\_\_\_

Home Address: \_\_\_\_\_  
\_\_\_\_\_

Single  Married  Divorced  Widowed  Separated

Hm #: (\_\_\_\_) \_\_\_\_\_ Pager/Cell: \_\_\_\_\_

Wk #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_ DL #: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

How long there? \_\_\_\_\_ Occupation: \_\_\_\_\_

Where & when are best times to reach you? \_\_\_\_\_  
\_\_\_\_\_

Whom may we Thank for referring you? \_\_\_\_\_

Other family members seen by us: \_\_\_\_\_  
\_\_\_\_\_

Previous/Present Dentist: \_\_\_\_\_

Last Visit Date: \_\_\_\_\_

## SPOUSE INFORMATION

His/Her Name: \_\_\_\_\_

Employer: \_\_\_\_\_

Wk #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_ SS#: \_\_\_\_\_

Birthdate: \_\_\_/\_\_\_/\_\_\_ DL #: \_\_\_\_\_

Person Responsible for Account: \_\_\_\_\_

Wk #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_ Hm #: (\_\_\_\_) \_\_\_\_\_

Billing Address: \_\_\_\_\_

Relationship: \_\_\_\_\_ SS #: \_\_\_\_\_

Employer: \_\_\_\_\_ DL: \_\_\_\_\_

# Medical History

## INSURANCE

### Primary Insurance

Dental Coverage?  Yes  No

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone #: (\_\_\_\_) \_\_\_\_\_

Group # (Plan, Local or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Insured's Birthdate: \_\_\_/\_\_\_/\_\_\_ Insured's ID #: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

### Secondary Insurance

Dental Coverage?  Yes  No

Insurance Co Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone #: (\_\_\_\_) \_\_\_\_\_

Group # (Plan, Local or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Insured's Birthdate: \_\_\_/\_\_\_/\_\_\_ Insured's ID #: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

### Neighbor or Relative not living with you.

His/Her Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Wk #: (\_\_\_\_) \_\_\_\_\_ Hm #: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

## MEDICAL HISTORY

Do you have a personal physician?  Yes  No

Physician's Name: \_\_\_\_\_

Phone #: (\_\_\_\_) \_\_\_\_\_ Date of last visit: \_\_\_\_\_

Are you currently under the care of a physician?  Yes  No

Please explain: \_\_\_\_\_

**MEDICAL HISTORY - continued**

Your current physical health is:  Good  Fair  Poor

Do you smoke or use tobacco in any other form?  Yes  No

Have you had any metal rods, pins or implants?  Yes  No

Are you taking any prescription/over-the-counter or herbal supplement drugs?  Yes  No

Please list each one: \_\_\_\_\_

Have you even taken Phen-Fen?  Yes  No  
(Also known as Redux or Pondimin)

If so, when? \_\_\_\_\_

**For Women:** Are you using a prescribed method of birth control?  Yes  No

Are you pregnant?  Yes  No Wk #: \_\_\_\_\_

Are you nursing?  Yes  No

**Have you ever had any of the following diseases or medical problems**

- Y N**
- Abnormal Bleeding
  - Alcohol/Drug Abuse
  - Anemia
  - Arthritis
  - Artificial Bones/Joints/Valves
  - Asthma
  - Blood Transfusion
  - Cancer/Chemotherapy
  - Colitis
  - Congenital Heart Defect
  - Diabetes
  - Difficulty Breathing
  - Emphysema
  - Epilepsy
  - Fainting Spells
  - Frequent Headaches
  - Glaucoma
  - Hay Fever
  - Heart Attack
  - Heart Murmur
  - Heart Surgery
  - Hemophilia
  - Hepatitis

- Y N**
- Herpes/Fever Blisters
  - High Blood Pressure
  - HIV+/AIDS
  - Hospitalized for any reason
  - Kidney Problems
  - Liver Disease
  - Low Blood Pressure
  - Lupus
  - Mitral Valve Prolapse
  - Pacemaker
  - Psychiatric Problems
  - Radiation Treatment
  - Rheumatic/Scarlet Fever
  - Seizures
  - Shingles
  - Sickle Cell Disease/Traits
  - Sinus Problems
  - Stroke
  - Thyroid Problems
  - Tuberculosis (TB)
  - Ulcers
  - Venereal Disease

Please list any serious medical condition(s) that you have ever had:

\_\_\_\_\_

Are you allergic to any of the following?

- |            |                    |              |
|------------|--------------------|--------------|
| <b>Y N</b> | <b>Y N</b>         | <b>Y N</b>   |
| Aspirin    | Erythromycin       | Tetracycline |
| Codeine    | Latex              | Other        |
| Penicillin | Dental Anesthetics |              |

Please list any other drugs/materials that you are allergic to:

**DENTAL HISTORY**

Why have you come to the dentist today? \_\_\_\_\_

Do you require antibiotics before dental treatment?  Yes  No

Are you currently in pain?  Yes  No

Have you ever had a serious/difficult problem associated with any previous dental work?  Yes  No

Have you ever had gum treatment?  Yes  No

**Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)?**  Yes  No

Your current dental health is  Good  Fair  Poor

Do you like your smile?  Y  N

Do your gums ever bleed?  Y  N

How many times a week do you floss? \_\_ a day do you brush?\_\_

Type of bristles?  Soft  Medium  Hard

How long do you use a toothbrush before replacing it? \_\_\_\_\_

Are your teeth sensitive to heat, cold, or anything else? \_\_\_\_\_

Have you lost any teeth?  Yes  No If yes, why? \_\_\_\_\_

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Payment is due in full at the time of treatment**  
Unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Our office is HIPPA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.