DENVER PLACE
DENTISTRY

Welcome

Name:_____ **Today's Date**_____

I like to be called : _____ **Date of Birth:** _____

Home address:_____ **Social Security Number:**

_____ _____

Employer:_____ **Cell Number:**_____

Occupation:_____ **Work Number:**_____

Marital Status: __ Single __Married __Divorced __Widowed **Email:** _____

Spouse's name:_____ **How did you hear about us?** _____

If a patient, whom? _____

Insurance Information

Company:_____ **Policy holder:**_____

Policy holder DOB: _____ **Relationship to policy holder:** _____

Subscriber's ID: _____ **Group #**_____

Dental History

Date of your last dental visit: _____ **Previous dentist name:** _____

Why have you come to see us today? _____

How would you describe the condition of your teeth and gums? ___Good ___ Fair ___ Poor

Are you currently in pain or discomfort with you teeth and gums? ___ Yes ___ No

If yes, please explain:_____

How often do you brush your teeth? _____ **How often do you floss your teeth?** _____

Do your gums bleed when you brush? ___Yes ___No Do you grind your teeth? ___Yes ___No

Have you ever been treated for TMJ symptoms? ___Yes ___No

If yes, please explain: _____

Health History

Have you been Hospitalized in the last 5 years? ___ Yes ___ No

If yes, for what? _____

Are you receiving care: ___ Yes ___ No If yes, nature of care?_____

Date of last health exam: _____ **What was the exam for?** _____

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Please list any physicians who are currently providing you with care:_____

For the following questions, please check all that apply. Your answers are for our record only and will be confidential. Please note that during your initial visit you will be asked some question about your response. Our team may ask additional questions concerning your health.

__ Heart murmur (mitral valve prolapse)
__ Anemia
__ Diabetes
__ Epilepsy
__ Hepatitis, any form
__ Rheumatic fever
__ Asthma
__ HIV positive or AIDS related complications
__ Sexually Transmitted Disease (STD)
__ Emphysema or other respiratory illnesses
__ Abnormal heart condition
__ Kidney Disease
__ Heart (surgery disease, attack)

___ Psychosis
___ Sore/enlarged lymph nodes
___ Previous biopsies
___ Slow- healing mouth sores
___ Other infections
___ Joint Replacement
___ Glaucoma
___ Abnormal bleeding from a cut
___ Liver disease
____ Jaundice
____Unintentional weight loss/gain
____ Latex sensitivity
____ Osteoporosis

Are you required to Pre-Medicate before dental treatment? Yes No
Abnormal blood pressure? Yes No
If yes, what is it usually: S_____/D_____ (Example 120/80)

Women ONLY:
Are you Pregnant? Yes No
If no, are you planning a pregnancy in the near future? Yes No
Are you a nursing mother? Yes No
Are you taking birth control pills? Yes No

Are you a smoker? Yes No
If yes, how much do you smoke per day? _____

Please list any medications you are currently taking:
_____
_____
_____

Are you allergic or have you had a reaction to:
__Local anesthetic
__Penicillin or other antibiotics
__Aspirin
__ Codeine, Valium or other sedatives
__ Nitrous Oxide
__ Other_____

Diet:
Restricted Diet _____

Food Allergies _____
_____
_____

Sugar in your diet: ____ None ____Slight ___Moderate ___ High___

I have been given the opportunity to review the Right to Privacy Notice: (Int.) _____

The undersigned herby authorized Doctor to take x-rays , study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (patients name) _____ and further authorize the use of my clinical slides/photography for educational or promotional purposes. I also understand that the use anesthetic agents embodies a certain risk. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time of services are rendered unless financial arrangements have been made. I further understand that a 1.5% finance charge (18% annually) will be added to any balance over 30days. In the event of default, I promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to affect collection of this note. I have been provided to review the office privacy policy & received a copy. I also understand this policy is available for my review at any time. I have reviewed and acknowledge the cancellation policy.

Patient _____ Date: _____ Witness_____

Patient or Responsible Party _____ Relationship to Patient_____