Patient Information

(Please print) DATE ______________

NAME ______________ PREFERRED NAME ______________

ADDRESS ______________ CITY ______________ STATE ______ ZIP ______

BIRTHDATE ______________ PHONE ______________

SS # ______________ E-MAIL ______________

CHECK APPROPRIATE BOX: ❑ MINOR ❑ SINGLE ❑ MARRIED ❑ DIVORCED ❑ WIDOWED ❑ SEPARATED

PARENT/GUARDIAN'S NAME ______________ PHONE ______________

PERSON TO CONTACT IN CASE OF AN EMERGENCY ______________ PHONE ______________

WHOM MAY WE THANK FOR REFERRING YOU ______________

Responsible Party

****Please complete this section if the person responsible for this account is someone other than the patient****

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT ______________

RELATIONSHIP TO PATIENT ______________ PHONE ______________

ADDRESS ______________ CITY ______________ STATE ______ ZIP ______

BIRTHDATE ______________ SS # ______________

EMPLOYER ______________ WORK PHONE ______________

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ❑ YES ❑ NO

Dental Insurance Information

Do you have dental insurance? ❑ *YES* ❑ *NO*

Please present your insurance card

NAME OF INSURED ______________ RELATIONSHIP TO PATIENT ______________

BIRTHDATE ______________ SS # ______________ NAME OF EMPLOYER ______________

INSURANCE COMPANY ______________ CONTRACT ID # ______________

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? ❑ YES ❑ NO IF YES, COMPLETE THE FOLLOWING:

Please present your insurance card

NAME OF INSURED ______________ RELATIONSHIP TO PATIENT ______________

BIRTHDATE ______________ SS # ______________ NAME OF EMPLOYER ______________

INSURANCE COMPANY ______________ CONTRACT ID # ______________

Dental History

REASON FOR THIS VISIT ______________

DATE OF LAST DENTAL VISIT ______________ WHAT WAS DONE ______________

HOW OFTEN DID YOU VISIT THE DENTIST BEFORE THEN ______________

PREVIOUS DENTIST (NAME AND LOCATION) ______________

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE?

____

Patient Medical History

Are you under a physician's care now? ❑ Yes ❑ No If yes ____________________

Have you ever been hospitalized or had a major operation? ❑ Yes ❑ No If yes ____________________

Have you ever had a serious head or neck injury? ❑ Yes ❑ No If yes ____________________

Are you taking any medications, pills or drugs? ❑ Yes ❑ No If yes ____________________

Do you take, or have you taken Phen-Fen or Redux? ❑ Yes ❑ No If yes ____________________

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ❑ Yes ❑ No If yes ____________________

Are you on a special diet? ❑ Yes ❑ No Do you use tobacco? ❑ Yes ❑ No

Women: Are you...

❑ Pregnant/Trying to get pregnant? ❑ Nursing? ❑ Taking oral contraceptives?

Are you allergic to any of the following? ❑ None

❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic

❑ Metal ❑ Latex ❑ Sulfa Drugs ❑ Local Anesthetics

❑ Other____________________

Do you use controlled substances? ❑ Yes ❑ No If yes ____________________

Do you have, or have you had, any of the following? (please check all that apply)

❑ AIDS/HIV Positive
❑ Alzheimer's Disease
❑ Anaphylaxis
❑ Anemia
❑ Angina
❑ Arthritis/Gout
❑ Artificial Heart Valve
❑ Artificial Joint
❑ Asthma
❑ Blood Disease
❑ Blood Transfusion
❑ Breathing Problems
❑ Bruise Easily
❑ Cancer
❑ Chemotherapy
❑ Chest Pains
❑ Cold Sores/Fever Blisters
❑ Congenital Heart Disorder
❑ Convulsions
❑ Cortisone Medicine
❑ Diabetes
❑ Drug Addiction
❑ Easily Winded
❑ Emphysema
❑ Epilepsy or Seizures
❑ Excessive Bleeding
❑ Excessive Thirst
❑ Fainting Spells/Dizziness
❑ Frequent Cough
❑ Frequent Diarrhea
❑ Frequent Headaches
❑ Genital Herpes
❑ Glaucoma
❑ Hay Fever
❑ Heart Attack/Failure
❑ Heart Murmur
❑ Heart Pacemaker
❑ Heart Trouble/Disease
❑ Hemophilia
❑ Hepatitis A
❑ Hepatitis B or C
❑ Herpes
❑ High Blood Pressure
❑ High Cholesterol
❑ Hives or Rash
❑ Hypoglycemia
❑ Irregular Heartbeat
❑ Kidney Problems
❑ Leukemia
❑ Liver Disease
❑ Low Blood Pressure
❑ Lung Disease
❑ Mitral Valve Prolapse
❑ Osteoporosis
❑ Pain in Jaw Joints
❑ Parathyroid Disease
❑ Psychiatric Care
❑ Radiation Treatments
❑ Recent Weight Loss
❑ Renal Dialysis
❑ Rheumatic Fever
❑ Rheumatism
❑ Scarlet Fever
❑ Shingles
❑ Sickle Cell Disease
❑ Sinus Trouble
❑ Spina Bifida
❑ Stomach/Intestinal Disease
❑ Stroke
❑ Swelling of Limbs
❑ Thyroid Disease
❑ Tonsillitis
❑ Tuberculosis
❑ Tumors or Growths
❑ Ulcers
❑ Venereal Disease
❑ Yellow Jaundice

Have you ever had any serious illness not listed? ❑ Yes ❑ No If yes____________________

I certify that the information I have provided for myself or my minor child, including the health questionnaire, is correct to the best of my knowledge. I acknowledge that I have had an opportunity to receive a copy of this office's Notice of Privacy Practices. I authorize Dr. Paulson to perform dental treatment on me or my minor child. This treatment may include the administration of local anesthetic and its associated risks. These risks include but are not limited to paresthesia, needle breakage, trismus and visible bruising. I understand that I am responsible for the total balance of my account, regardless of what my dental insurance may or may not cover. If I have dental insurance, I hereby authorize payment of all dental insurance benefits directly to Dr. Paulson.

Authorized Signature____________________ **Date**____________________