SERENE HILLS DENTISTRY

dentistry done differently

NAME: _____
LAST FIRST MI TITLE

PREFERRED NAME: _____ SEX: MALE FEMALE

ADDRESS: _____CITY _____ STATE _____ ZIP _____

SSN: _____ DOB:_____

HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____ E-MAIL: _____

EMPLOYER: _____ OCCUPATION: _____

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED SEPARATED

How did you hear about us? _____

Do you prefer to be contacted for appointment confirmation via e-mail, phone or text? (Please circle)

INSURANCE- PRIMARY

Subscriber Name: _____ Relationship to patient: _____

Subscriber DOB: _____ Subscriber Employer: _____

Insurance Company Name: _____ Subscriber ID: _____

Insurance Company Address: _____

Insurance Company Phone: _____ Group Number: _____

INSURANCE- SECONDARY

Subscriber Name: _____ Relationship to patient: _____

Subscriber DOB: _____ Subscriber Employer: _____

Insurance Company Name: _____Subscriber ID:_____

Insurance Company Address: _____

Insurance Company Phone: _____ Group Number: _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Serene Hills Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____

Relationship: _____ Date: _____

EMERGENCY CONTACT

NAME:_____ RELATIONSHIP: _____

ADDRESS: _____ PHONE: _____

MEDICAL HISTORY

Do you have a personal physician? YES NO

Physician's Name: _____ Physician's Phone: _____

Date of Last Visit: _____

Your current physical health is: GOOD FAIR POOR

Are you currently under the care of physician? YES NO

Please explain: _____

Are you pregnant? YES NO DUE DATE: _____

Do you use tobacco in any form? YES NO If yes, what form: _____

Do you drink alcohol? YES NO If yes, how many alcoholic drinks per week? _____

Have you had any total joint replacements? YES NO If yes, which? _____

Do you have a history of Subacute Bacterial Endocarditis(SBE) or an artificial heart valve? YES NO

Are you taking any medications? YES NO If yes, please list below

NAME AND DOSAGE OF MEDICATION	APPROXIMATE START DATE	REASON FOR TAKING MEDICATION

Have you ever had any surgical procedures? YES NO
Please list each one, including dates of the surgeries: _____

_____

YES	ALLERGIES
	ASPIRIN
	CODEINE
	VICODIN/HYDROCODONE
	IBUPROFEN/ADVIL/ALEVE
	TYLENOL/ACETAMINOPHEN
	PENICILLIN/AMOXICILLIN
	ERYTHROMYCIN/Z-PAK
	CLINDAMYCIN
	DENTAL ANESTHETICS

ALLERGIES NOT LISTED ABOVE: _____

YES	CONDITION	YES	CONDITION
	Abnormal Bleeding		Heart Attack Date:
	Alcohol/Drug Abuse (please circle)		Heart Surgery Date:
	Allergies		Heart Murmur
	Anemia		Heart Defect
	Angina Pectoris		Head Injury
	Arthritis		Hemophilia
	Artificial Heart Valve		Hepatitis A B C (please circle)
	Asthma		High Cholesterol
	Bleeding Disorders Type:		High or Low Blood Pressure (Please Circle)
	Blood Transfusion Date:		HPV Type (if known):
	Cancer Type: _____ Date:		Joint Replacement Type: _____ Date:
	Chemotherapy or Radiation (please circle)		Kidney Problems
	Colitis		Liver Disease
	Diabetes Type 1/ Type 2		Mitral Valve Prolapse
	Difficulty Breathing		Pace Maker
	Emphysema		Rheumatic Fever
	Epilepsy		Seizures
	Facial Surgery		Sexually Transmitted Disease
	Fainting Spells		Shingles
	Fever Blisters		Sickle Cell Anemia
	Frequent headaches		Sinus Problems
	GERD/Acid Reflux		Stroke
	Glaucoma		Thyroid Problems (hyper/hypo) (please circle)
	HIV + AIDS		Tuberculosis

CONDITIONS NOT LISTED ABOVE: _____

DENTAL HISTORY

How may we help you today? _____

Do you have a history or oral or oropharyngeal cancer? YES NO If yes,_____

Do you require antibiotics before treatment? YES NO

Are you currently in pain? YES NO

Do you have any pain/discomfort in your jaw joint (TMJ)? YES NO

Do your gums bleed? YES NO

How many times do you: FLOSS/WEEK? _____ BRUSH/DAY? _____

Are your teeth sensitive to heat, cold or anything else? YES NO

Have you had any unfavorable dental experiences? YES NO

When was your last dental visit? _____ Dental cleaning? _____

How can we accommodate you better during your dental visit? _____

Do you like your smile? YES NO

Are you happy with the color of your teeth? YES NO

Are you interested in Clear Correct Braces? YES NO

Do you typically use nitrous (laughing gas) for dental procedures? YES NO

Is there anything you would like to speak privately to the doctor about? YES NO

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 strictest confidence and it is my responsibility to inform the office of any changes in my medical status.

Signature: _____ Date: _____