BAYSHORE

Dental ImageS

Grant Williams, DMD

Patient Information

*Name*_____ *Preferred name:* _____

Birthdate ____/____/____ *SSN* _____-_____-_____ *Address*_____
City State Zip

Home Phone: _____ *Cell Phone* _____ *Work Phone:* _____

Email: _____@_____.com *How do you prefer to be contacted for appointments?*
Is it OK to leave voicemail message ❒Yes ❒No OR with a person ❒Yes ❒No *❒Phone ❒Text ❒Email*

Check Appropriate Box: ❒Minor ❒Single ❒Married ❒Separated ❒Divorced ❒Widowed

Spouse or Guardian Name: _____ *Phone* _____

***Emergency Contact**:* _____ *Phone* _____

Responsible Party

Name of Person Responsible for this Account? _____ *Relationship to Patient* _____

*Address*_____ *Phone:* _____

Birthdate _____/_____/_____ *SSN* _____-_____-_____ *Employer:* _____

Insurance Information

For your convenience, we offer the following methods of payment. ❒Cash ❒Personal Check ❒Visa ❒Master Card
*Do you have Insurance? ❒**Yes** (Complete the following) ❒**No**, I would you like to discuss the Office's Payment Policy*

Name of Insured _____ *Relationship to Patient* _____

Birthdate _____/_____/_____ *SSN* _____-_____-_____ *Employer:* _____

Insurance Company _____ *Member ID#* _____ *Group #*_____

Insurance Company Phone # _____ *Address* _____

Secondary Insurance

Name of Insured _____ *Relationship to Patient* _____

Birthdate _____/_____/_____ *SSN* _____-_____-_____ *Employer:* _____

Insurance Company _____ *Member ID#* _____ *Group #*_____

Insurance Company Phone # _____ *Address* _____

Authorization & Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such Dental are to third party payors and/health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient: _____ *Date:* _____

38505 Brooten Rd., Suite B ♦ PO Box 818, Pacific City, OR 97135
(503) 965-0014 ♦ www.bayshoredentalimages.com

PATIENT MEDICAL HISTORY

Physician: _____ Phone: _____ Last Exam:_____

YES	NO	
		1. Are you under continued medical treatment?
		2. Have you ever been hospitalized for any surgical operation or serious illness in the last 5 years?
		3. Are you taking any medication(s) including over the counter / non-prescriptions? *Please list:*_____
		4. Do you take any blood thinners? (e.g. Aspirin, Coumadin, Xarelto, etc.)
		5. Are you, or have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?
		6. Do you or have you used tobacco? If yes: ❒ Current - OR - _____ Date you quite
		7. Do you use controlled substances?
		8. Do you have a persistent cough or throat clearing **NOT** associated with a known illness? (lasting more than 3 weeks)
		9. Do you wear medically prescribed skin patches for things such as back pain? (Lidocaine Patches)
		10. Have you been screened for a Sleep Disorder (such as sleep Apnea) If Yes: Do you currently have a CPAP? ❒Yes ❒No

11. Are you allergic to or have you had any reactions to the following?

- ☐ Local Anesthetics (e.g. Novocain)
- ☐ Penicillin or any other Antibiotics
- ☐ Sulfa Drugs
- ☐ Barbiturates
- ☐ Latex Rubber
- ☐ Iodine
- ☐ Aspirin
- ☐ Any Metals (e.g. nickel, mercury, etc)
- ☐ Other: _____

12. Women Only:

- ☐ Are you pregnant or think you may be pregnant?
- ☐ Are you Nursing? ☐Are you taking oral contraceptives?

13. Do you have or have you had any of the following:

- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Heart Attack
- ☐ Mitral Valve Prolapse
- ☐ Fainting/Seizures
- ☐ Swollen Ankles
- ☐ Epilepsy/Convulsions
- ☐ Diabetes - ❒ Type 1 ❒ Type 2
- ☐ Heart Murmur
- ☐ Cardiac pacemaker
- ☐ Chest pains
- ☐ Heart Disease
- ☐ Stroke
- ☐ Anemia
- ☐ Cancer
- ☐ HIV or AIDS infection
- ☐ Respiratory Problems
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Radiation Therapy
- ☐ Glaucoma
- ☐ Liver Disease
- ☐ Leukemia
- ☐ Thyroid Problem
- ☐ Arthritis
- ☐ Joint Replacement / Implant
- ☐ Hepatitis / Jaundice
- ☐ Stomach Troubles/Ulcers
- ☐ Kidney Disease

Other: _____

PATIENT DENTAL HISTORY

Previous Dentist: _____ Date of Last Exam: _____

YES	NO	
		Do your gums bleed while brushing or flossing?
		Are your teeth sensitive to hot or cold liquids / food?
		Do you feel pain to any of your teeth?
		Do you have any sores or lumps in or near your mouth?
		Have you had any head, neck or jaw injuries?
		Do you clench or grind your teeth?
		Have you had any orthodontic treatment?

YES	NO	
		Have you ever experienced any of the following problems in your jaw
		Clicking
		Pain (joint, ear, side of face)
		Difficulty opening or closing
		Difficulty in chewing
		Do you have frequent headaches?
		Do you bite your lips or cheeks frequently?
		Do you wear dentures or partials?
		If yes: Date of Placement _____

RECALL REVIEW

Patient's signature: _____ *Date:* _____

Patient's signature: _____ *Date:* _____

Patient's signature: _____ *Date:* _____

Doctor's Comments: _____

_____

_____

*Signature:*_____ *Date:*_____

38505 Brooten Rd., Suite B ♦ PO Box 818, Pacific City, OR 97135
(503) 965-0014 ♦ www.bayshoredentalimages.com