Welcome

to

Ruland Family Dentistry

Patient Information (Confidential) **Today's Date _____**

Name _____ Birthdate _____ S.S. # _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address: _____

Minor ___ Single ____ Married ___ Divorced ___ Separated ___ Widowed ___ Partnered ___

Employer Name _____ Work Number _____

Employer's Address _____ City _____ State _____ Zip _____

Who May We Thank for Referring You? _____

Responsible Party

Name of Person Responsible for this Account _____

Address _____ Relationship to Patient_____

Home Phone _____ Work Phone _____ Cell Phone _____

DENTAL Insurance Information - (Please have staff copy your card)

Name of Insured _____ Relationship to Patient _____ S.S. # _____

Name of Insurance Company _____ Policy Holders Birthdate _____ Policy # _____

Employer Name _____ Date Insurance went into effect _____

Group # _____ Address to Submit Claims_____

Is Patient a Student? Where _____ Full Time _____ Part Time _____

Additional Insurance

Name of Insured _____ Date Insurance went into effect _____ S.S. # _____

Name of Insurance Company _____ Policy Holders Birthdate _____ Policy # _____

Group # _____ Address to Submit Claims _____

Dental History

Bad breath	__yes __no	Burning on tongue	__yes __no	Clicking or popping jaw	__yes __no
Food collection in teeth	__yes __no	Gums swollen or tender	__yes __no	Loose teeth/broken fillings	__yes __no
Orthodontic treatment	__yes __no	Sensitivity to cold	__yes __no	Sensitivity when biting	__yes __no
Bleeding gums	__yes __no	Chew one side of mouth	__yes __no	Dry mouth	__yes __no
Foreign objects	__yes __no	Jaw Pain or Tiredness	__yes __no	Mouth breathing	__yes __no
Pain around ear	__yes __no	Sensitivity to heat	__yes __no	Sores/growths in mouth	__yes __no
Blisters on lips or mouth	__yes __no	Cigarette, etc. smoker	__yes __no	Fingernail biting	__yes __no
Grinding teeth	__yes __no	Lip or cheek biting	__yes __no	Mouth Pain, brushing	__yes __no
Periodontal treatment	__yes __no	Sensitivity to sweets	__yes __no		

Over →

Patients Medical History

Physician _____ Office Phone _____ Date last exam _____

Person to Contact in case of Emergency _____ Number _____

Do you have any conditions that require <u>PREMEDICATION</u> before your dental visit, such as Artificial Heart Valves, History of Infective Endocarditis, or Joint replacements? _____YES ____ NO

<u>Place a mark on "Yes" or "No" to indicate if you have had any of the following:</u>

Bleeding abnormally, extractions/surgery	__yes __no	Cough, Persistent or bloody	__yes __no	Cortisone Treatments	__yes __no
Emphysema	__yes __no	Blood Disease	__yes __no	Low Blood Pressure	__yes __no
Ulcer	__yes __no	High Blood Pressure	__yes __no	Mitral Valve Prolapse	__yes __no
Hepatitis Type ___	__yes __no	Swollen Neck Glands	__yes __no	Liver Disease	__yes __no
Heart Murmur	__yes __no	Chemical Dependency	__yes __no	Venereal Disease	__Yes __no
AIDS/HIV	__yes __no	Circulatory Problems	__yes __no	Tuberculosis	__yes __no
Epilepsy	__yes __no	Jaundice	__yes __no	Diabetes	__yes __no
Respiratory Disease	__yes __no	Kidney Disease	__yes __no	Herpes	__yes __no
Anemia	__yes __no	Thyroid Problems	__yes __no	Back Problems	__yes __no
Fainting/Dizziness	__yes __no	Stroke	__yes __no	Heart Problems	__yes __no
Rheumatic Fever	__yes __no	Chemotherapy	__yes __no	Weight Loss, unexplained	__yes __no
Arthritis, Rheumatism	__yes __no	Jaw Pain	__yes __no	Pacemaker	__yes __no
Glaucoma	__yes __no	Tonsillitis	__yes __no	Special Diet	__yes __no
Scarlet Fever	__yes __no	Nervous Problems	__yes __no	Cancer	__yes __no
Artificial Heart Valves	__yes __no	Heart Attack	__yes __no	Swollen Feet/Ankles	__yes __no
Headaches	__yes __no	Sinus Trouble	__yes __no	Tumor/growth on head or neck	__yes __no
Shortness of Breath	__yes __no	Skin Rash	__yes __no	Do you wear contacts	__yes __no
Artificial Joints	__yes __no	Psychiatric Care	__yes __no		
Asthma	__yes __no	Congential Heart lessions	__yes __no		
Radiation treatment	__yes __no				

WOMEN

Are you pregnant? __yes __no Due Date _____

Are you nursing? __yes __no Are you taking birth control pills? ___yes ___no

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

_____

_____

__

Pharmacy Name: _____

Phone:_____

ALLERGIES

___ Aspirin ___ Iodine ___ Penicillin ___ Barbiturates (Sleeping Pills)

___ Amoxicillin ___ Latex ___ Sulfa ___ **No known Allergies**

___ Codeine ___ Local Anesthetic ___ Other(s) _____

Authorization and 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 the records of any treatment or examinations rendered to me or my child during the period of such Dental care to third party payors and/or 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.

X_____ Date _____ Doctor Initials _____

Signature of patient (or parent/guardian if minor) Hygienist Initials_____

(Updated 05-15-2010)