

PAGE FAMILY DENTAL HEALTH FORM

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely.
The better we communicate, the better we can care for you.

| | |
|---|---|
| <p style="text-align: center;"><u>ABOUT YOU</u></p> <p>Today's Date: _____</p> <p>Email: _____</p> <p>Name: <small>LAST</small> _____ <small>FIRST</small> _____</p> <p>I prefer to be called: _____</p> <p>Birthdate ___/___/___ SS#: _____</p> <p>Home Address: _____</p> <p>_____</p> <p><input type="checkbox"/>Single <input type="checkbox"/>Married <input type="checkbox"/>Divorced <input type="checkbox"/>Widowed <input type="checkbox"/>Separated</p> <p>Cell: (____) _____ Hm: : (____) _____</p> <p>Wk: (____) _____ Ext: _____</p> <p>When/Where is best to reach you? _____</p> <p>Employer: _____</p> <p>Occupation: _____</p> <p>How did you hear about us? _____</p> <p>Other family seen by us: _____</p> <p>Previous dentist: _____</p> <p>Prev Dent Phone(____) _____</p> <p>Last Visit date ___/___/___</p> | <p style="text-align: center;"><u>INSURANCE</u></p> <p>Dental Coverage? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Insurance Co Name: _____</p> <p>Insurance Co Address _____</p> <p>Insurance Co Phone # (____) _____</p> <p>Group # (Plan, Local, or Policy #): _____</p> <p>Insured's name: _____</p> <p>Relationship: _____</p> <p>Insured's b.d. ___/___/___</p> <p>Insured's SS# _____</p> <p>Insured's employer: _____</p> <p>Employer's Address: _____</p> <p>_____</p> |
| <p style="text-align: center;"><u>SPOUSE INFORMATION</u></p> <p>His/Her Name: _____</p> <p>Employer: _____</p> <p>Wk #: (____) _____ Ext: _____</p> <p>Birthdate ___/___/___ SS#: _____</p> <p>Person responsible for account:</p> <p>Name: _____</p> <p>Wk #: (____) _____ Ext: _____</p> <p>Billing address: _____</p> <p>_____</p> <p>Relationship: _____</p> <p>Employer: _____</p> <p>SS#: _____</p> | <p style="text-align: center;"><u>SECONDARY INSURANCE</u></p> <p>Dental Coverage? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Insurance Co Name: _____</p> <p>Insurance Co Address _____</p> <p>Insurance Co Phone # (____) _____</p> <p>Group # (Plan, Local, or Policy #): _____</p> <p>Insured's name: _____</p> <p>Relationship: _____</p> <p>Insured's b.d. ___/___/___</p> <p>Insured's SS# _____</p> <p>Insured's employer: _____</p> <p>Employer's Address: _____</p> <p>_____</p> |
| <p style="text-align: center;"><u>MEDICAL HISTORY</u></p> <p>Do you have a personal physician? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Physician's name: _____</p> <p>Phone # (____) _____ Date of last visit ___/___/___</p> <p>Are you currently under the care of a physician? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>If yes, please explain: _____</p> <p>_____</p> <p>Your current physical health is: <input type="checkbox"/>Good <input type="checkbox"/>Fair <input type="checkbox"/>Poor</p> <p>Do you smoke or use tobacco of any form? <input type="checkbox"/>Yes <input type="checkbox"/>No Type: _____</p> <p>Are you taking any prescription, over the counter, or herbal supplement drugs: <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Do you take Fossamax or Actonel: <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Please list each one: _____</p> <p>_____</p> | <p style="text-align: center;"><u>FOR WOMEN ONLY</u></p> <p>Are you taking birth control pills: <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Are you pregnant: <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Are you nursing: <input type="checkbox"/>Yes <input type="checkbox"/>No</p> |

MEDICAL HISTORY (continued)

Have you ever had any of the following diseases or medical problems?

| | |
|--------------------------|--|
| Cardiovascular disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Angina | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congestive heart disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Damaged heart valve | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart attack | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Low blood pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| High Blood pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Abnormal bleeding | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hemophilia | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alcohol/Drug abuse | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood transfusion | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer/Chemotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Radiation treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Herpes/Cold sores | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Kidney problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Liver disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Lupus | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Sinus Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| HIV/AIDS | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Mitral valve prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Psychiatric problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Rheumatic fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Shingles | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Sickle cell disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Sinus problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Thyroid disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Venereal disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |

MEDICAL HISTORY (continued)

Are you **allergic** or have you had a reaction to any of the following?

| | |
|---|--|
| Local anesthetic | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Aspirin | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Penicillin or other antibiotics | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Sulfa drugs | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Barbiturates, sedatives, sleeping pills | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Codeine or other narcotics | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Latex | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Food | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Other: | |

Have you had any of the following (which may require premedication prior to dental work)?

| | |
|--|--|
| Joint replacement | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If yes, when? | |
| Artificial heart valves | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Infective endocarditis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Damaged valves in transplanted heart | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital heart disease (CHD) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Unrepaired, cyanotic CHD | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Repaired (completely) in last 6 months | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Repaired CHD with residual effects | <input type="checkbox"/> Yes <input type="checkbox"/> No |

DENTAL

Why have you come to the dentist today? _____

Are you currently in pain? Yes No
 Have you ever had gum treatment? Yes No
 Do you experience pain/discomfort in your jaw joints? Yes No
 Do your gums bleed? Yes No
 Are you happy with your smile? Yes No
 How many times a week do you floss? _____ brush?
 Are your teeth sensitive to heat, cold, or anything else? _____
 Your current dental health is:
Good Fair Poor

I understand that the information given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence. It is my responsibility to inform this office of any changes in my medical status. signature _____ date ____/____/____

If this office accepts my insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any copayments or deductibles that my insurance does not cover. I hereby authorize payment to Page Family Dental of the group insurance benefits otherwise payable to me. I understand that I am responsible for the cost of all dental treatment. I hereby authorize release of any information including diagnosis and records of treatment or examination to my insurance company. I hereby agree to be responsible for all costs of collection for delinquent accounts. signature _____ date ____/____/____