

Dental History

Name of previous dentist _____

May we request your previous dental records to facilitate proper treatment in our office? _____

What prompted you to seek dental care at this time? _____

How long since your last thorough dental exam? _____ Cleaning? _____ X-rays? _____

Are you self-conscious about the appearance of your teeth? _____

How often do you have your teeth examined? _____ Were x-rays of all teeth taken? _____

At your last dental visit, what treatment was rendered? _____

Has the fear of discomfort kept you from regular dental visits? _____

Would you prefer a local anesthetic for most dental treatment? _____

How often do you brush your teeth? _____ Floss? _____

Are you troubled with bad breath? _____ Do your gums bleed easily, feel tender? _____

Are your teeth sensitive to hot, cold or sweets? _____

Do you frequently snack between meals on sweets, starches or chew gum? _____

Would you like to retain your healthy natural teeth as long as possible? _____

Do your jaws feel tired? _____ Do you have pain in your head, neck, shoulders or back? _____

Do you have clicking or popping noises when opening or closing your mouth? _____

Are you aware of grinding or clenching of your teeth? _____

Medical History

Physician's Name _____ Phone Number (____) _____

When was your last thorough medical exam? _____

Are you being treated by a physician now? _____ Please explain: _____

Are you taking any medications? _____ Please list: _____

Do you take any vitamin or nutritional supplements? _____

Are you allergic to any medications? _____ Please list: _____

Are you allergic to any metals? _____ Please list: _____

Have you had any recent serious illness or surgeries? _____ Please list: _____

Please put a check mark if you have had any of the following:

<input type="checkbox"/> Heart attack, stroke	<input type="checkbox"/> Heart trouble, murmur or valvular disorder	<input type="checkbox"/> Artificial joints	<input type="checkbox"/> Venereal disease or herpes
<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Mitral valve prolapse	<input type="checkbox"/> Blood disorders	<input type="checkbox"/> Currently pregnant
<input type="checkbox"/> Artificial heart valves	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Persistent cough or coughing up blood	<input type="checkbox"/> Emotional stress
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Eye disorders	<input type="checkbox"/> AIDS or HIV+
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Allergic to anesthetic	<input type="checkbox"/> Respiratory disease	<input type="checkbox"/> Cancer, tumors or malignancies
<input type="checkbox"/> Kidney or liver disorder	<input type="checkbox"/> Smoking or smokeless tobacco	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Anemia
<input type="checkbox"/> Asthma		<input type="checkbox"/> Radiation treatments	<input type="checkbox"/> Epilepsy / Seizures
<input type="checkbox"/> Hepatitis		<input type="checkbox"/> Chemotherapy	
<input type="checkbox"/> Other: _____			

I certify that I have read and understand the above and that my answers are complete and accurate. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I understand it is my responsibility to inform this office of any changes in my medical status.

Signature _____ **Date** _____

Doctor	Date _____	Initials _____	Date _____	Initials _____	Date _____	Initials _____
Review	Date _____	Initials _____	Date _____	Initials _____	Date _____	Initials _____

WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

Patient Information

Date _____ Home Phone (____) _____ Cell Phone (____) _____
Name _____ Address _____
City _____ State _____ Zip _____ E-mail _____
Male _____ Female _____ Age _____ Birthdate (month) _____ (day) _____ (year) _____
Social Sec. # _____ Single _____ Married _____ Divorced _____ Widowed _____ Minor _____
Spouse's/Parent's Name _____
Patient Employer _____ Occupation _____ How Long? _____
Business Address _____ Business Phone (____) _____
Whom may we thank for referring you? _____
Person to contact in emergency _____ Emergency Phone (____) _____

Dental Insurance

Insured's Name _____ Relation to patient _____
Birthdate (month) _____ (day) _____ (year) _____ Social Sec. # _____
Address (if different from patient) _____ Phone (____) _____
City _____ State _____ Zip _____
Insured's Employer _____ Occupation _____ How Long? _____
Business Address _____ Business Phone (____) _____
Insurance Company _____
Group # _____ Identification # _____

Please let our receptionist copy your insurance card. Thank you.

Insurance Authorization

I hereby authorize the office of Brant P. Rouse, D.D.S., PLC to affix my name to all insurance submissions, documents, and/or information requested by my insurance company(s) relating to any and all health benefits due to my dependents and me. I also authorize payment of healthcare benefits otherwise payable to me, directly to my dentist as listed above. I agree to be held responsible for all charges and services not paid by my insurance company.

Signature _____ Date _____

Acknowledgement of receipt of Notice of Privacy Practices

I _____ have received a copy of this office's Notice of Privacy Practices.

PRINT FULL NAME

Signature _____ Date _____

Office use only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because: _____ Individual refused to sign _____ Communication barriers _____ Emergency situation _____ Other _____

(Over)