*Preferred*Dental

1771 NW Burdett Crossing, Blue Springs, MO 64015
816-228-0001

PATIENT INFORMATION (CONFIDENTIAL)

Name _____Birthday _____SSN_____

Address _____City_____State_____ Zip_____

Phones: Hm:_____Wk:_____Cell:_____

EMAIL:_____

Marital Status: Single _____ Married _____ Child _____

Male_____ Female_____

Occupation_____ Employer & Address_____

Spouses' Occupation_____Employer & Address_____

How or who referred you to our office?_____

Person to contact in case of emergency?_____Phone_____

INSURANCE INFORMATION

Name of Insured _____Insurance Company_____

Group # _____Policy/ID #_____Union or Local #_____

If insured is someone other than you:

Name_____Birthday_____SSN_____

Employer _____Relationship to patient _____

PATIENT MEDICAL HISTORY

Physician_____ Office Phone_____ date of last exam_____

__yes __no Are you under medical treatment now?
__yes __no Are you taking any medications including non-prescription medicine?
If yes please LIST:_____

_____

__yes __no Have you ever taken Phen-fen/Redux?
__yes __no Do you use tobacco**? If yes please circle one:** cigarettes or chewing tobacco
__yes __no Do you use controlled substances?
__yes __no Are you wearing contact lenses?

DO YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING?

__Y __N High blood Pressure
__Y __N Heart Attack
__Y __N Rheumatic Fever
__Y __N Swollen Ankles
__Y __N Fainting / Seizures
__Y __N Asthma
__Y __N Thyroid Problem
__Y __N Heart Disease
__Y __N Cardiac Pacemaker
__Y __N Heart Murmur
__Y __N Angina
__Y __N Frequently Tired
__Y __N Anemia
__Y __N Emphysema
__Y __N Cancer
__Y __N Arthritis
__Y __N Joint Replacement or Implant
__Y __N Hepatitis / Jaundice
__Y __N Sexually Transmitted Disease
__Y __N Stomach Troubles
__Y __N Low Blood Pressure
__Y __N Epilepsy/Convulsions
__Y __N Leukemia
__Y __N Diabetes
__Y __N Kidney Disease
__Y __N Aids or HIV Infection
__Y __N Ulcers
__Y __N Chest Pains
__Y __N Easily Winded
__Y __N Stroke
__Y __N Hay Fever / Allergies
__Y __N Tuberculosis
__Y __N Radiation Therapy
__Y __N Glaucoma
__Y __N Recent Weight Loss
__Y __N Liver Disease
__Y __N Heart Trouble
__Y __N Respiratory Problems
__Y __N Mitral Valve Prolapse
Other _____

ARE YOU ALLERGIC TO OR HAVE HAD ANY REACTIONS TO THE FOLLOWING?

__Y __N Local Anesthetics (e.g. Novocain)
__Y __N Penicillin or other antibiotics
__Y __N Sulfa Drugs
__Y __N Barbiturates
__Y __N Sedatives
__Y __N Codeine
__Y __N Aspirin
__Y __N Any Metals (Nickel, mercury, etc.)
__Y __N Latex Rubber
Other:_____

Women Only:
__Y __N Are you pregnant
__Y __N Are you nursing
__Y __N Are you taking oral contraceptives

PATIENT DENTAL HISTORY

__Y __N Do your gums bleed while brushing or flossing
__Y __N Are your teeth sensitive to hot or cold liquids/foods
__Y __N Are your teeth sensitive to sweet or sour liquids/foods
__Y __N Do you feel pain in any of your teeth
__Y __N Do you have any sores or lump near your mouth
__Y __N Have you had any head/neck injuries
__Y __N Do you have frequent headaches
__Y __N Do you clench or grind your teeth
__Y __N Have you had difficult extractions in the past
__Y __N Prolonged bleeding after extractions
__Y __N Have you had orthodontic treatment
__Y __N Do you wear dentures/partials
Have you ever experienced any of the following problems in your jaw?
__Y __N Clicking
__Y __N Pain (joint, ear, side of face)
__Y __N Difficulty in opening or closing
__Y __N Difficulty in chewing
_____How do you rate your smile?
From 1-10 1(poor) – 10 (great)

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 Preferred Dental to release any information including diagnosis and the records of any treatment or examination 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 Preferred Dental otherwise payable to me. ***I understand that my dental insurance carrier my pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my behalf or my dependents.***

_____ _____

Signature of patient (or parent if minor) ***date***