*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 #________________

<u>If insured is someone other than you:</u>

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***