Date: ______________________

Patient Information

Patient Name: ______________________

Birthdate: ____________ Sex: M ☐ F ☐

Address: ______________________

____

SS#/HIC/ID#: ______________________

Email: ______________________

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Phone Numbers:

Home: ______________________

Cell: ______________________

Work: ____________ Ext: ________

Best Number to Contact: Home / Cell / Work

Occupation: ______________________

Patient Employer/School: ______________________

Employer/School Address: ______________________

____

Spouse's Name ______________________

Spouse's Birthdate: ______________________

Spouse's ID#/SS#: ______________________

Spouse's Employer: ______________________

Whom may we thank for referring you?

____

Dental Insurance

Subscriber: ______________________

Relationship to Patient: ______________________

Insurance Co.: ______________________

Group#: ______________________

Is Patient covered by additional Insurance? ☐ Yes ☐ No

If No, please skip to 'Assignment and Release.'

Additional Insurance Information:

Subscriber's Name: ______________________

Birthdate: ____________ ID#: ____________

Relationship to Patient: ____________ Group#: ________

Insurance Co.: ______________________

Assignment and Release:

I certify that I, and/or my dependent(s), have insurance coverage with ________________________ and assign directly to BANNAI FAMILY DENTISTRY all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

____

Signature of Patient,Parent, Guardian or Personal Representative

______________________ ______________________

Relationship to Patient Date

Dental History

			Dry mouth	☐ Yes	☐ No	Mouth breathing	☐ Yes	☐ No
Bad Breath	☐ Yes	☐ No	Fingernail biting	☐ Yes	☐ No	Orthodontic treatment	☐ Yes	☐ No
Bleeding Gums	☐ Yes	☐ No	Food collection between teeth	☐ Yes	☐ No	Pain around ear	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No	Foreign objects	☐ Yes	☐ No	Periodontal treatment	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No	Grinding teeth	☐ Yes	☐ No	Sensitivity to cold	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No	Gums swollen or tender	☐ Yes	☐ No	Sensitivity to hot	☐ Yes	☐ No
Chewing of tobacco	☐ Yes	☐ No	Jaw pain or tiredness	☐ Yes	☐ No	Sensitivity to sweets	☐ Yes	☐ No
Cigarette, Pipe, or Cigar smoking	☐ Yes	☐ No	Lip or cheek biting	☐ Yes	☐ No	Sensitivity when biting	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No	Loose teeth or broken fillings	☐ Yes	☐ No	Sores or growths in your mouth	☐ Yes	☐ No

Reason for Today's Visit: ______________________ Are you in pain? ☐Yes ☐No For how long? ____________

Date of Last Dental Visit: ______________________ Date of Last Dental Xrays: ______________________

Former Dentist: ______________________

Medical History

Physician's Name: ______________________ Specialty: ____________________ Phone#: ______________

Do you have or have you had any of the following diseases, medical conditions or procedures?

Condition	Yes / No	Condition	Yes / No	Condition	Yes / No
AIDS/HIV	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Fainting or dizziness	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Artificial Heart Valves	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Headaches, severe/frequent	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Heart Problems	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes ☐ No	Hepatitis Type ________	☐ Yes ☐ No	Special Diet	☐ Yes ☐ No
		Herpes	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Swollen Feet or Ankles	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Congenital Heart Lesions	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Tumor or growth on head or neck	☐ Yes ☐ No
Cortisone Treatments	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No		
Cough, persistent or bloody	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
		Psychiatric Care	☐ Yes ☐ No	Weight Loss, unexplained	☐ Yes ☐ No

Please list any other medical condition(s) you have or ever had: ______________________________

____

Do you wear contact lenses? ☐ Yes ☐ No

Women:

Are you pregnant? ☐ Yes ☐ No Due date: ____________________ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

Have you ever been told to Premedicate or take Antibiotics prior to having dental procedures done? ☐ Yes ☐ No

Have you ever taken any of the group drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Pondimin (fenfluramine), Redux (dexfenfluramine), and Fastin (brand names of phentermine)? ☐ Yes ☐ No

Are you taking any of the following medications?

- ☐ Medication for Anxiety
- ☐ Pain Killers (Including Aspirin)
- ☐ Muscle Relaxers
- ☐ Stimulants
- ☐ Blood Thinners (Coumadin)
- ☐ Tranquilizers
- ☐ Insulin

MEDICATIONS:

Please list any medications you are currently taking and the correlating diagnosis:

____________________ ____________________

____________________ ____________________

____________________ ____________________

____________________ ____________________

Pharmacy: ______________________________

Phone#: ______________________________

ALLERGIES:

- ☐ Aspirin
- ☐ Barbituates (Sleeping Pills)
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Penicillin / Amoxicillin
- ☐ Sulfites
- ☐ Sulfa Drugs
- ☐ Tetracycline
- ☐ Other ____________

EMERGENCY CONTACT: ______________________

Relationship to Patient: Phone#: ______________

______________________ Phone#: ______________

I have received a copy of the **Patient Privacy Notices** as required by law ______________________

Patient Signature

I have received a copy of the newest 2004 **Dental Materials Facts Sheet** ______________________

Patient Signature