

R. Lee Clitheroe, D.D.S., F.I.C.D., F.A.C.D.

Patient Information

Date _____ E-mail _____

Patient Name _____ M _____ F _____
Last First Middle

Address _____
Street City State Zip

How long at this address _____ Home Phone _____ Cell/Work Phone _____

Previous Address (If less than three years) _____

Social Security # _____ Birth Date _____ Marital Status _____

Employer _____ Occupation _____ No. Years Employed _____

Hobbies/Interest _____ If Applicable: School _____ Grade _____

Children & Ages _____

Whom may we thank for referring you to our office? _____

Responsible Party or Spouse Information

Name _____ Relationship to Patient _____
Last First Middle

Address _____ Home Phone _____

Dental Insurance Information

Insured's Name _____ Insurance ID # _____ Date of Birth _____

Insurance Co. _____ Group No. _____

Insurance Co. Address _____

Insurance Co. Telephone No. _____ Insured's Employer _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____

MEDICAL HEALTH

Name and address of physician _____

Have you been under a Physician's care during the past 2 years? _____ For? _____

Have you been treated in a hospital in the past 2 years? _____ For? _____

Have you ever had major surgery? _____ Explain _____

If female: Are you taking hormones or birth control? _____ Are you pregnant or nursing? _____

Have you ever had a blood test for hepatitis? _____ Were you vaccinated? _____

Do you smoke or chew tobacco? _____

Are you now taking or have you taken any prescription drugs during the past year? (Please list on back) _____

Are you taking Blood thinners daily? _____

Are you allergic to: Penicillin _____ Codeine _____ Local anesthetics _____ Latex _____ Other _____

Have you had or do you now have?

	Yes	No		Yes	No		Yes	No
AIDS/HIV.....	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy.....	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged bleeding.....	<input type="checkbox"/>	<input type="checkbox"/>
Allergies.....	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric treatment.....	<input type="checkbox"/>	<input type="checkbox"/>
Anemia.....	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Radiation therapy.....	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis.....	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever.....	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valves.....	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell anemia.....	<input type="checkbox"/>	<input type="checkbox"/>
Artificial joints (Hip, Knee etc.)	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>
Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve prolapse.....	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers.....	<input type="checkbox"/>	<input type="checkbox"/>
Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	Organ transplant.....	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease.....	<input type="checkbox"/>	<input type="checkbox"/>

Have you any disease, condition or problem not previously listed? _____

DENTAL HEALTH

When was your last dental visit? _____

How often did you see your dentist? _____

Are you having any dental problems that require immediate attention? _____

Do any of the following cause tooth discomfort? Hot _____ Cold _____ Sweet _____ Chewing _____

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

Do your gums bleed while cleaning? _____

Do your gums ever feel tender or swollen? _____

Have you had periodontal (gum) treatment? _____ When? _____

Do you clench or grind your teeth? _____

Do your jaws ever feel tired or ache? _____ Click or pop? _____

Can you chew on both sides of your mouth? _____ Comfortably? _____

Do you have frequent headaches? _____ Earaches? _____

Have you ever had orthodontic treatment (braces)? _____ When? _____

Have you ever had your teeth ground or bite adjusted? _____

Do you usually have many cavities? _____

Do you have any loose teeth? _____ Cracked or broken teeth? _____

Do you have any noticeable wear on your teeth? _____ Food traps? _____

Do you have any missing teeth? _____ Have they been replaced? _____

If so, how? Fixed bridge _____ Removable partial _____ Full denture _____ Dental implant _____

Are you comfortable with the replacement? _____ Please describe _____

How do you feel about the appearance of your smile? _____

Have you ever had any cosmetic dentistry done to improve your appearance? _____

If yes, are you pleased with the results? _____ **Please comment** _____

Have you ever had any unpleasant dental experiences? _____

Please add anything you feel is important: _____

List current medications- _____

CONSENT FOR TREATMENT

1. The undersigned hereby authorizes the Doctor to perform all the necessary diagnostic procedures deemed appropriate.

2. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment in full is due at the time of service unless other arrangements have been made.

PATIENT SIGNATURE (PARENT OF CHILD)

DATE

DENTIST SIGNATURE

DATE