

WELCOME TO CEDAR CREEK DENTAL

PATIENT INFORMATION

Date _____

First Name _____ M.I. ____ Last Name _____
Sex Male Female Birth Date _____ Age ____ Soc. Sec. # _____ E-mail _____
Street _____ City _____ State ____ Zip _____
Home Tel. (____) _____ Cell (____) _____ Have you ever been a patient of our practice? Y N
Previous Dentist _____ Referred By _____
Nearest relative not living with you _____ Tel. (____) _____
Employer _____ Bus. Tel. (____) _____ Personal payment type: Cash Check Credit Card
In case of emergency, please contact _____ Tel. (____) _____ Relation _____

Who will be responsible for your account?

 Self Spouse Father Mother Other _____

(If self, skip to next section)

Name _____ S.S. # _____ Birth Date _____ Age ____ Tel. (____) _____
Street _____ City _____ State ____ Zip _____
Employer _____ Bus. Tel. (____) _____

Spouse or other guarantor information (if different from above)

Name _____ Relation _____ S.S. # _____ Birth Date _____
Street _____ City _____ State ____ Zip _____
Tel. (____) _____ Employer _____ Bus. Tel. (____) _____

INSURANCE INFORMATION

Student: Full Time Part Time Not School Name/Address _____
 Married Divorced Legally Separated Widow Single _____
Employed: Full Time Part Time Retired Not _____

PRIMARY INSURANCE COMPANY

Insurance Type: Dental Medical
Employer _____
Bus. Address _____
Bus. Tel. (____) _____ Plan _____
Ins. Co. Name _____
Address _____
Tel. (____) _____
Group # _____ Group Name _____
Insured Party _____ Relation _____
Sex: M F Birth Date _____
Street _____
City, State, Zip _____
Tel. (____) _____ S.S. # _____
I.D. # _____

SECONDARY INSURANCE COMPANY

Insurance Type: Dental Medical
Employer _____
Bus. Address _____
Bus. Tel. (____) _____ Plan _____
Ins. Co. Name _____
Address _____
Tel. (____) _____
Group # _____ Group Name _____
Insured Party _____ Relation _____
Sex: M F Birth Date _____
Street _____
City, State, Zip _____
Tel. (____) _____ S.S. # _____
I.D. # _____

DENTAL INFORMATION

Reason for today's visit Exam Consultation Emergency Are you in pain? Y N, For how long? _____

Please indicate any of the following problems by checking off the corresponding box:

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Discomfort, clicking or popping jaw | <input type="checkbox"/> Lost / broken filling(s) | <input type="checkbox"/> Stained teeth | <input type="checkbox"/> Difficulty closing jaw |
| <input type="checkbox"/> Red, swollen or bleeding gums | <input type="checkbox"/> Teeth grinding / clenching | <input type="checkbox"/> Locking jaw | <input type="checkbox"/> Difficulty opening jaw |
| <input type="checkbox"/> A removable dental appliance | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Loose / shifting teeth |
| <input type="checkbox"/> Blisters / sores in or around mouth | <input type="checkbox"/> Broken / chipped tooth | <input type="checkbox"/> Burning tongue / lips | <input type="checkbox"/> Food caught between teeth |
| <input type="checkbox"/> Prolonged bleeding from an injury / extraction | <input type="checkbox"/> Gum disease | <input type="checkbox"/> Toothache | <input type="checkbox"/> Swelling / lumps in mouth |
| <input type="checkbox"/> Recent infections or sore throat | <input type="checkbox"/> Other: _____ | | |
| <input type="checkbox"/> My teeth are sensitive to: | | | |
| <input type="checkbox"/> Hot | <input type="checkbox"/> Cold | | |
| <input type="checkbox"/> Sweets | <input type="checkbox"/> Biting | | |

Last dental exam _____ Last dental x-rays _____ Times a day you brush? ____ Times a week you floss? ____

How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best)

MEDICAL HISTORY

Physician's Name _____ Phone (____) _____

Address _____

Any illness, operation or been hospitalized in the past 5 years? Y N Have you been told you need to pre-med for a dental appt? Y N

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

- | | | | |
|--|---|--|--|
| Y N | Y N | Y N | Y N |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bleeding tendency | <input type="checkbox"/> Low blood sugar |
| <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Hay fever / Sinus problems | <input type="checkbox"/> Jaundice / Liver disease | <input type="checkbox"/> Kidney trouble |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Snoring / Sleep apnea | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Are you on dialysis |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Respiratory problems | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Arthritis / Joint disease |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Infectious mononucleosis | <input type="checkbox"/> Stomach ulcers |
| <input type="checkbox"/> Chest pain / Angina | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Gallbladder trouble | <input type="checkbox"/> Contagious diseases |
| <input type="checkbox"/> Heart attack(s) | <input type="checkbox"/> Do you smoke | <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Delay in healing |
| <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Do you use chewing tobacco | <input type="checkbox"/> Convulsions / Epilepsy | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Cardiac pacemaker | <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Stroke | <input type="checkbox"/> Tumor or growth |
| <input type="checkbox"/> Heart surgery | <input type="checkbox"/> Blood disorder | <input type="checkbox"/> Thyroid trouble | <input type="checkbox"/> Radiation / Chemotherapy |
| <input type="checkbox"/> Bronchitis / Chronic cough | <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Are you on a diet |
| <input type="checkbox"/> Chronic fatigue / Night sweat | <input type="checkbox"/> A history of drug abuse | <input type="checkbox"/> A history of alcohol abuse | <input type="checkbox"/> Contact lenses |
| <input type="checkbox"/> Mental health problems | <input type="checkbox"/> Eye disease / Glaucoma | <input type="checkbox"/> Sexually transmitted diseases | <input type="checkbox"/> Immune system problems |
| <input type="checkbox"/> Damaged heart valves | <input type="checkbox"/> Abnormal bleeding | <input type="checkbox"/> Swollen ankles | <input type="checkbox"/> Malignant hyperthermia |
| <input type="checkbox"/> Are you immunosuppressed?
(possibly from transplant surg.) | <input type="checkbox"/> Problems w/ immune system?
(possibly from med. / surg.) | | |

MEDICATION AND ALLERGIES

Are you now taking or have you taken:

- | | | | |
|--|---|--|--|
| Y N | Y N | Y N | Y N |
| <input type="checkbox"/> Nerve pills | <input type="checkbox"/> Pain killers (including aspirin) | <input type="checkbox"/> Muscle relaxers | <input type="checkbox"/> Stimulants |
| <input type="checkbox"/> Have you ever taken diet pills | <input type="checkbox"/> Tranquilizers | <input type="checkbox"/> Insulin | <input type="checkbox"/> Antidepressants |
| <input type="checkbox"/> Blood thinners
(Coumadin, Aspirin, Advil) | Please list any other medication(s) you are taking (including natural, herbal or homeopathic products): | | |
| <input type="checkbox"/> Any bone density medication
or Bisphosphonates (Aredia,
Zometa, Fosamax, Actonal) | _____ | | |
| | _____ | | |

Are you allergic to or had a reaction to:

- | | | | |
|--|--------------------------------------|---|---|
| Y N | Y N | Y N | Y N |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Sulfa drugs | <input type="checkbox"/> Local anesthetic (numbing med) | <input type="checkbox"/> Sodium pentothal |
| <input type="checkbox"/> Valium or other tranquilizers | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Codeine or other narcotics | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Soy | <input type="checkbox"/> Eggs / Yolk | <input type="checkbox"/> Sulfites | <input type="checkbox"/> Amoxicillin |

Please list any other medication or antibiotic you are allergic to:

Please list any allergies other than drug allergies:

1-4 below for women only: (women note: antibiotics (such as penicillin) may alter the effectiveness of birth control pills. consult your physician / gynecologist for assistance regarding additional methods of birth control.)

- 1) Is there a possibility of pregnancy? Y N
3) Are you nursing? Y N

- 2) Expected delivery date _____
3) Are you taking birth control pills? Y N

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature of patient: X

Reviewed by: X

Date: X

FEES AND PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and / or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company. You will be responsible for all collection costs, attorneys fees and court costs.

Signature of patient: (parent or guardian if minor) X

Date: X

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

Signature of patient: (parent or guardian if minor) X

Date: X

I hereby acknowledge that a copy of this office's policy and Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions that I may have regarding these notices.

Signature of patient: (parent or guardian if minor) X

Date: X