

SPRABERRY DENTAL CLINIC

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PATIENT INFORMATION

CONFIDENTIAL

DATE _____

(PLEASE PRINT)

NAME _____ FEMALE MALE

BIRTHDATE _____ SS # _____ MINOR SINGLE MARRIED DIVORCED

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ FAX # _____ CELLULAR PHONE _____

PATIENT'S EMPLOYER _____ WORK PHONE _____

OCCUPATION _____

EMAIL ADDRESS _____

SPOUSE'S NAME _____ EMPLOYER _____ WORK PHONE _____

IF PATIENT IS A STUDENT, NAME OF SCHOOL / COLLEGE _____ CITY _____ STATE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

RESPONSIBLE PARTY (PARENT/GUARDIAN)

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE _____

SOCIAL SECURITY # _____ BIRTHDATE _____

EMPLOYER _____ WORK PHONE _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? YES NO

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SOCIAL SECURITY NUMBER _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX. ANNUAL BENEFIT? _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? YES NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SOCIAL SECURITY NUMBER _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX. ANNUAL BENEFIT? _____

PATIENT MEDICAL HISTORY

PATIENT NAME

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST PHYSICAL EXAM _____
 DATE OF LAST DENTAL VISIT _____

1. ARE YOU UNDER MEDICAL TREATMENT NOW? YES NO

2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS? YES NO

3. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE? YES NO
 IF YES, WHAT MEDICATION(S) ARE YOU TAKING? _____

4. DO YOU USE: TOBACCO? YES NO ALCOHOL? YES NO
 COCAINE? YES NO OTHER DRUGS? YES NO

5. ARE YOU WEARING CONTACT LENSES? YES NO

6. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING?
 YES NO YES NO YES NO
 LOCAL ANESTHETICS (EG. NOVOCAINE) BARBITURATES ASPIRIN
 PENICILLIN OR OTHER ANTIBIOTICS SEDATIVES OTHER _____
 SULFA DRUGS IODINE

7. WOMEN ONLY: YES NO
 A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT? YES NO
 B) ARE YOU NURSING? YES NO
 C) ARE YOU TAKING BIRTH CONTROL PILLS? YES NO

8. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

YES NO	YES NO	YES NO
<input type="checkbox"/> <input type="checkbox"/> AIDS OR HIV INFECTION	<input type="checkbox"/> <input type="checkbox"/> FREQUENTLY TIRED	<input type="checkbox"/> <input type="checkbox"/> LOW BLOOD PRESSURE
<input type="checkbox"/> <input type="checkbox"/> ANEMIA	<input type="checkbox"/> <input type="checkbox"/> GLAUCOMA	<input type="checkbox"/> <input type="checkbox"/> RADIATION THERAPY
<input type="checkbox"/> <input type="checkbox"/> ANGINA	<input type="checkbox"/> <input type="checkbox"/> HAY FEVER / ALLERGIES	<input type="checkbox"/> <input type="checkbox"/> RECENT WEIGHT LOSS
<input type="checkbox"/> <input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> <input type="checkbox"/> HEART ATTACK	<input type="checkbox"/> <input type="checkbox"/> RESPIRATORY PROBLEMS
<input type="checkbox"/> <input type="checkbox"/> ASTHMA	<input type="checkbox"/> <input type="checkbox"/> HEART DISEASE	<input type="checkbox"/> <input type="checkbox"/> RHEUMATIC FEVER
<input type="checkbox"/> <input type="checkbox"/> CANCER	<input type="checkbox"/> <input type="checkbox"/> HEART MURMUR	<input type="checkbox"/> <input type="checkbox"/> SEXUALLY TRANSMITTED DISEASE
<input type="checkbox"/> <input type="checkbox"/> CARDIAC PACEMAKER	<input type="checkbox"/> <input type="checkbox"/> HEART TROUBLE	<input type="checkbox"/> <input type="checkbox"/> STOMACH TROUBLES / ULCERS
<input type="checkbox"/> <input type="checkbox"/> CHEST PAINS	<input type="checkbox"/> <input type="checkbox"/> HEPATITIS / JAUNDICE	<input type="checkbox"/> <input type="checkbox"/> STROKE
<input type="checkbox"/> <input type="checkbox"/> DIABETES	<input type="checkbox"/> <input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="checkbox"/> <input type="checkbox"/> SWOLLEN ANKLES
<input type="checkbox"/> <input type="checkbox"/> EASILY WINDED	<input type="checkbox"/> <input type="checkbox"/> JOINT REPLACEMENT OR IMPLANT	<input type="checkbox"/> <input type="checkbox"/> THYROID PROBLEM
<input type="checkbox"/> <input type="checkbox"/> EMPHYSEMA	<input type="checkbox"/> <input type="checkbox"/> KIDNEY DISEASE	<input type="checkbox"/> <input type="checkbox"/> TUBERCULOSIS
<input type="checkbox"/> <input type="checkbox"/> EPILEPSY / CONVULSIONS	<input type="checkbox"/> <input type="checkbox"/> LEUKEMIA	<input type="checkbox"/> <input type="checkbox"/> OTHER _____
<input type="checkbox"/> <input type="checkbox"/> FAINTING / SEIZURES	<input type="checkbox"/> <input type="checkbox"/> LIVER DISEASE	

COMMENTS

SIGNATURE OF DENTIST _____ DATE _____

PATIENT DENTAL HISTORY

	YES	NO		YES	NO
1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?	<input type="checkbox"/>	<input type="checkbox"/>	9. DO YOU CLENCH OR GRIND YOUR TEETH?	<input type="checkbox"/>	<input type="checkbox"/>
2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS?	<input type="checkbox"/>	<input type="checkbox"/>	10. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY?	<input type="checkbox"/>	<input type="checkbox"/>
3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS?	<input type="checkbox"/>	<input type="checkbox"/>	11. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST?	<input type="checkbox"/>	<input type="checkbox"/>
4. DO YOU FEEL PAIN TO ANY OF YOUR TEETH?	<input type="checkbox"/>	<input type="checkbox"/>	12. HAVE YOU HAD ANY ORTHODONTIC WORK?	<input type="checkbox"/>	<input type="checkbox"/>
5. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?	<input type="checkbox"/>	<input type="checkbox"/>	13. HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS?	<input type="checkbox"/>	<input type="checkbox"/>
6. HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES?	<input type="checkbox"/>	<input type="checkbox"/>	14. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING YOUR TEETH?	<input type="checkbox"/>	<input type="checkbox"/>
7. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?			15. HAVE YOU EVER HAD INSTRUCTIONS ON THE CARE OF YOUR GUMS?	<input type="checkbox"/>	<input type="checkbox"/>
A) CLICKING?	<input type="checkbox"/>	<input type="checkbox"/>	16. ARE YOU INTERESTED IN HAVING YOUR TEETH LIGHTENED?	<input type="checkbox"/>	<input type="checkbox"/>
B) PAIN (JOINT, EAR, SIDE OF FACE)?	<input type="checkbox"/>	<input type="checkbox"/>			
C) DIFFICULTY IN OPENING OR CLOSING?	<input type="checkbox"/>	<input type="checkbox"/>			
D) DIFFICULTY IN CHEWING?	<input type="checkbox"/>	<input type="checkbox"/>			
8. DO YOU HAVE FREQUENT HEADACHES?	<input type="checkbox"/>	<input type="checkbox"/>			

SIGNATURE

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 WILL INFORM THE DENTIST OF ANY CHANGE IN MY MEDICAL STATUS. I AUTHORIZE SPRABERRY DENTAL CLINIC TO FURNISH INFORMATION TO THE INSURANCE CARRIERS CONCERNING MY TREATMENT. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE. IN THE CASE OF DEFAULT OF PAYMENT, I PROMISE TO PAY ANY LEGAL INTEREST, COLLECTION COSTS AND ATTORNEY FEES FOR THE RECOVERY OF THIS ACCOUNT. I AUTHORIZE THE DENTAL STAFF TO PERFORM ANY NECESSARY DENTAL SERVICES, WITH MY INFORMED CONSENT, THAT I MAY NEED DURING DIAGNOSIS AND TREATMENT.

X

 PATIENT, PARENT OR GUARDIAN

 DATE