Roadt Family Dental

Name ____ Date of Birth ________________ Male ☐ Female ☐

If child: Parent's Name _______________________________________How do you wish to be addressed _______________________

Address ____ City __________________ Zip_______________

Home phone _____________________________________ Alternate phone ____

Patient employed by ____ Patient's SSN ______________________________

Other family members in this practice ______________________________ Whom may we thank for this referral___________________

Dental insurance company _______________________________________Person responsible for account ______________________

If other than yourself: SSN ______________________________ DOB ____

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be liable for payment of services not paid, by my dental care payor.

I attest to the accuracy of the information on this page.

PATIENT'S / GUARDIAN'S SIGNATURE____ Date ______________________

MEDICAL HISTORY

Name of physician ____When was your last physical exam? _______________________

Are you now under the care of a physician? Yes☐ No ☐ If yes, for what reason? ______________________________________

Are you presently taking any medications or substances? Yes☐ No ☐
Please list:____

Are you allergic to any medications? Yes☐ No ☐ If yes, please list ____

Are you sensitive or allergic to latex? Yes ☐ No ☐

Have you had any other serious illness, hospitalization or accident? Yes☐ No ☐ If yes, please explain _________________________

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Are you pregnant? Yes☐ No ☐ If yes, how long? ________________________ Do you use any birth control medications? Yes☐ No ☐

Are you or have you ever taken any Bisphosphonates? i.e. Alendronate (Fosamax), Pamidronate (Aredia), or Zometa Yes☐ No ☐

Do you have or ever had:

Condition			Condition		
Heart (surgery, disease, pacemaker)	Yes	No	Arthritis/Rheumatism	Yes	No
Rheumatic fever	Yes	No	Hearing impaired	Yes	No
Heart murmur	Yes	No	Blood disorders or excessive bleeding	Yes	No
Artificial heart valve	Yes	No	Anemia, Leukemia, etc	Yes	No
Mitral valve prolapse	Yes	No	Fainting spells	Yes	No
High or low blood pressure	Yes	No	Asthma or hay fever	Yes	No
Ulcers	Yes	No	Emphysema	Yes	No
Tuberculosis or lung disease	Yes	No	Sinus trouble	Yes	No
Diabetes	Yes	No	Cancer/Tumors/Lesions	Yes	No
Epilepsy/Seizure disorder	Yes	No	Chemotherapy/radiation	Yes	No
Thyroid problems	Yes	No	Stroke	Yes	No
Kidney problems	Yes	No	Glaucoma	Yes	No
Liver disease	Yes	No	Psychiatric care / eating disorder	Yes	No
Hepatitis – Type A B C	Yes	No	Artificial joint/Prosthesis	Yes	No
HIV positive / AIDS / ARC	Yes	No			

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DENTAL HISTORY

What is the reason for your visit today?______________________________

Previous Dentist's name______________________ Address______________________

Date of last visit______________________ Last x rays ______________________

How often do you have dental examinations? ______________________

How often do you brush your teeth? ______________________ How often do you floss?______________________

Do you have any dental problems now? Yes No If yes, please explain______________________

Are any of your teeth sensitive to:			**Have you ever had:**		
Hot or cold?	Yes	No	Orthodontic treatment?	Yes	No
Sweets?	Yes	No	Oral surgery?	Yes	No
Biting?	Yes	No			
			Teeth removed?	Yes	No
Have you noticed mouth odor?	Yes	No	If so, have they been replaced?	Yes	No
Do you get cold sores or blisters?	Yes	No			
Do your gums bleed or hurt?	Yes	No	A fixed bridge?	Yes	No
Has anyone in your family ever had gum disease?	Yes	No	A removable partial denture?	Yes	No
Have you ever noticed loose teeth or change in your bite?	Yes	No	A complete denture?	Yes	No
Does food get caught in your teeth?	Yes	No	An implant?	Yes	No
			Are you happy with the replacement?	Yes	No
Do you:			**Have you ever experienced:**		
Clench or grind your teeth?	Yes	No	Clicking or popping of the jaw?	Yes	No
Have tired jaws, especially in the morning?	Yes	No	Difficulty opening or closing the mouth?	Yes	No
Mouth breathe while asleep or awake?	Yes	No	Any pain or soreness in the muscles of your face or around the ears?	Yes	No
Smoke or chew tobacco?	Yes	No			
			Frequent headaches, neck aches, or shoulder aches?	Yes	No
Do you feel anxiety about having dental treatment?	Yes	No	**Are you happy with the appearance of your teeth?**	Yes	No

Have you had gum treatment or surgery?	Yes	No	If so, what and when?
Have you ever had a serious injury to the mouth or head?	Yes	No	If so, please describe

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. I acknowledge I have received a Notice of Privacy Practices from Roadt Family Dental and that any information will only be released to myself unless otherwise noted.

Patient's/Guardian's signature ______________________ Date ____________

Doctor's signature ______________________ Date ____________

Anest.

Med alert