

WELCOME

Today's date: _____

PATIENT INFORMATION

Name: _____ Married Single
I prefer to be called: _____ Male Female
Mailing Address: _____ Zip _____
Birth Date: _____ Home Phone: _____
Work Phone: _____ Other #: _____
Place of employment: _____ Social Security #: _____
Whom may we thank for referring you to our office? _____

PERSON RESPONSIBLE FOR ACCOUNT:

Name: _____ Relationship: _____
Mailing Address: _____
Home Phone: _____ Work Phone: _____
Other #: _____
Birth Date: _____ Social Security #: _____
Employer: _____ Do you have insurance through your employer? Yes No
Dental Insurance Co.: _____ Group #: _____

SECOND PERSON RESPONSIBLE FOR ACCOUNT/SPOUSE:

Name: _____ Relationship: _____
Mailing Address: _____
Home Phone: _____ Work Phone: _____
Other #: _____
Birth Date: _____ Social Security #: _____
Employer: _____ Do you have insurance through your employer? Yes No
Dental Insurance Co.: _____ Group #: _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY

Name: _____
Address: _____
City: _____
State: _____ Zip: _____
Phone: _____

AUTHORIZATION

The information on this page and the dental/medical histories are correct to the best of my knowledge. I understand that I am responsible for all costs of dental treatment. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals. I hereby authorize payment directly to Prairie Dental Care of the group insurance benefits otherwise payable to me. I hereby authorize the dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care.

Name: _____ Date: _____
 Adult Patient Father (or husband) Mother (or wife) Guardian
Drivers License # _____

Prairie Dental Care • 10001 NE 117th Avenue • Vancouver, WA 98662 • (360) 944-9800

Please Complete
Other Side

THANK YOU FOR CHOOSING PRAIRIE DENTAL CARE!

Name: _____ Date: _____

DENTAL HISTORY

1. What are your chief concerns? _____
2. Do your gums ever bleed? Yes No
3. Do you like your smile? Yes No
4. If you could, what would you change about your smile?
 - Close gaps Yes No
 - Fix chipped teeth Yes No
 - Replace missing teeth Yes No
 - Adjust size Yes No
 - Straighten crooked teeth Yes No
 - Whiten teeth Yes No
 - Other _____ Yes No
5. Does food catch between your teeth? Yes No
6. Any loose teeth? Where? _____ Yes No
7. Do you clench or grind your teeth? Yes No
8. Do you smoke tobacco? Yes No
9. Do you chew tobacco? Yes No
10. Do you snore? Yes No
11. Do you wake up well rested in the morning? Yes No
12. Do you have clicking, popping or discomfort in the jaw joint? Yes No

MEDICAL HISTORY

Your current medical condition is: Good Fair Poor
 Are you under a physicians care now? Yes No If yes, please explain: _____

Name of Physician: _____ Phone: _____

Are you taking any medications, pills or drugs? Yes No If yes, what? _____

Are you allergic to any medications or substances? If so, please **check box** below:

Aspirin Penicillin Codeine Acrylic Metal Latex Rubber Other

(Women only) Pregnant? How far along? _____ Nursing? Oral Contraceptives (What type?) _____

Do you have, or have you ever had any of the following?

Please mark box if you have experienced the following diseases or medical conditions

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Cancer | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> AIDS |
| <input type="checkbox"/> Heart Pace Maker | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> HIV Positive |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Stomach/Intestinal Disease | <input type="checkbox"/> Genital Herpes |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Hepatitis A (Infectious) | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Drug Addiction |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Cold Sores/Fever Blisters |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Tumors or Growths | <input type="checkbox"/> Epilepsy or Seizures |
| <input type="checkbox"/> Angina/Chest pain | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Fainting or dizziness |
| <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Tuberculosis | | <input type="checkbox"/> Alzheimer's disease |

Have you ever had any other serious illness not indicated above? Yes No If yes, explain _____

Do you wish to talk to the dentist privately about any problem? Yes No

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at my next appointment without fail.

Patient Signature (Parent or guardian if patient under 18) _____ Date _____

Reviewed by Doctor _____ Date _____ BP _____ History review and significant findings: _____

MEDICAL UPDATES

I have reviewed my Medical History dated _____ and confirm that it adequately states past and present conditions.

Date	Exceptions	Patient's Signature	BP	Reviewed by
_____	_____	None _____	_____	Dr. _____
_____	_____	None _____	_____	Dr. _____
_____	_____	None _____	_____	Dr. _____