

INSURANCE INFORMATION

DENTAL INSURANCE

PRIMARY DENTAL INSURANCE COMPANY _____

ADDRESS _____ PHONE # _____

INSURED'S NAME _____ RELATIONSHIP TO PATIENT _____

INSURED'S SS # ____/____/____ DATE OF BIRTH ____/____/____

INSURED'S EMPLOYER _____ GROUP _____

SECONDARY DENTAL INSURANCE COMPANY _____

ADDRESS _____ PHONE # _____

INSURED'S NAME _____ RELATIONSHIP TO PATIENT _____

INDURED'S SS # ____/____/____ DATE OF BIRTH ____/____/____

INSURED'S EMPLOYER _____ GROUP _____

MEDICAL INSURANCE

IF YOU HAVE MEDICAL INSURANCE PLEASE PROVIDE THE FOLLOWING:

PRIMARY MEDICAL INSURANCE COMPANY _____

ADDRESS _____ PHONE # _____

INSURED'S NAME _____ RELATIONSHIP TO PATIENT _____

INSURED'S SS # ____/____/____ DATE OF BIRTH ____/____/____

INSURED'S EMPLOYER _____ GROUP _____

SECONDARY MEDICAL INSURANCE COMPANY _____

ADDRESS _____ PHONE # _____

INSURED'S NAME _____ RELATIONSHIP TO PATIENT _____

INDURED'S SS # ____/____/____ DATE OF BIRTH ____/____/____

INSURED'S EMPLOYER _____ GROUP _____

I authorize release of information relating to my insurance claims made by this office. I understand that I am responsible for all costs of dental treatment and that this office will bill my insurance as a courtesy to me.

Patient Signature or Parent of a Minor

Date

Name _____ DOB _____

Medical Information *Please mark (X) as your response*

(Check DK if you Don't Know the answer to the question)

Yes No DK

Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?

Date: _____ If yes, have you had any complications? _____

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®), Prolia (Denosumab®) or risedronate (Actonel®) for osteoporosis or Paget's disease?

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?

Date Treatment began: _____

Allergies – Are you allergic or have you had a reaction to:
To all yes responses, specify type of reaction.

Yes No DK

Local anesthetics

Aspirin

Penicillin or other antibiotics

Barbiturates, sedatives, or sleeping pills

Sulfa drugs

Codeine or other narcotics

Metals

Latex (rubber)

Iodine

Hay fever/seasonal

Animals

Food

Other _____

Yes No DK

Artificial (prosthetic) heart valve

Previous infective endocarditis

Damaged valves in transplanted heart

Congenital heart disease (CHD)

Unrepaired, cyanotic CHD

Repaired (completely) in last 6 months

Repaired CHD with residual defects

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

Yes No DK

Cardiovascular disease

Angina

Arteriosclerosis

Congestive heart failure

Damaged heart valves

Heart attack

Heart murmur

Mitral valve prolapse

Pacemaker

Low blood pressure

High blood pressure

Other congenital heart defects

Rheumatic fever

Rheumatic heart disease

Abnormal bleeding

Anemia

Blood transfusion

If yes, date: _____

Hemophilia

AIDS or HIV infection

Arthritis

COVID-19

Medical Information *Please mark (X) as your response*

	Yes	No	DK		Yes	No	DK
Do you smoke Marijuana?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain upon exertion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If Yes, how often? _____				Chronic pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you use Edibles, THC or CBD Oils?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Type I or II.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If Yes, how often? _____				Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you use controlled substances (drugs)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Malnutrition.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been addicted to drugs (incl. recreational drugs).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please list drugs? _____				G.E. Reflux/persistent heartburn.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been in treatment for addiction? ..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco (smoking, snuff, chew, e-cigs)?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If so, how much?				Specify: _____			
If so, how interested are you in stopping? _____				Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(Circle one) VERY / SOMEWHAT / NOT INTERESTED				Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink alcoholic beverages?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bruise easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, how much alcohol did you drink in the last 24 hours? _____				Liver disease/Yellow jaundice.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, how much do you typically drink in a week? _____				Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a bad experience in the dental office?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been a patient in the hospital during the past two years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease (Syphilis, Gonorrhea).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you lost or gained more than 10 pounds in the last year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis, jaundice or liver disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you ever wake up from sleep short of breath?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells or seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specify: _____				Neurological disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, specify: _____			
Systemic lupus erythematosus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep disorder/Sleep Apnea.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental health disorders.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Specify: _____			
COPD/Emphysema.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Type of infection: _____			
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has your medical doctor ever said you have cancer or a tumor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Night sweats.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specify: _____				Osteoporosis/Osteopenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/Chemotherapy/Radiation Treatment....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Persistent swollen glands in neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mastectomy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe headaches/migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Side _____				Severe or rapid weight loss.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lumpectomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cold sores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Side _____				Sickle Cell disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lymphadenectomy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hearing aid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Side _____							

WOMEN ONLY Are you:

Pregnant?.....

Number weeks: _____

Taking birth control pills or hormonal replacement?

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?.....

Name of physician or dentist making recommendation: _____ Phone: _____

Do you have any disease, condition, or problem not listed above that you think I should know about?

Name _____ DOB _____

Medical Information *Please mark (X) as your response*

Who is your family doctor? _____

Are you now under care of a physician for any medical condition? **Yes** **No** **DK**

Physician Name: _____ Phone: Include area code _____

Address/City/State/Zip _____

Do you have Kaiser Medical Coverage?

What is your Kaiser # _____

Which Pharmacy would you like your prescriptions called into?

Are you in good health? **Yes** **No** **DK**

Recent accident or injuries?

Has there been any change in your general health within the past year?.....
If yes, what condition is being treated?

Date of last physical exam: _____

Height: _____ Weight: _____

Have you had a serious illness, operation or been hospitalized in the past 5 years?..... **Yes** **No** **DK**

If yes, what is the illness or problem?

Are you taking or have you recently taken any prescription or over the counter medicine(s)?.....
If so, please list all including prescription, vitamins natural or herbal medications and/or diet supplements. Please include all medication dosages.

