MADISON FAMILY DENTISTRY

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PATIENT INFORMATION

NAME: _____ ☐ married ☐ single ☐ separated ☐ divorced ☐ widowed

ADDRESS: _____
STREET APT.# CITY STATE ZIP

BIRTHDATE: _____ TELEPHONE: _____|_____|_____
MONTH DAY YEAR HOME OFFICE CELL

PLACE OF EMPLOYMENT: _____ S.S. #: _____

PRESENT POSITION: _____ EMAIL ADDRESS: _____

Whom may we thank for referring you to our office? _____

FAMILY INFORMATION

Spouse's Name: _____ Birthdate: _____/_____/_____

Telephone #: _____

Employer: _____

INSURANCE INFORMATION

Dental Insurance Company Name: _____ Phone: (_____)_____

Dental Claim Mailing Address: _____

City: _____ State: _____ Zip: _____

Name of Insured: _____ Sex: ☐ M ☐ F

Relationship of Patient to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Social Security Number of Insured: _____

Birthdate of the Insured: _____

Name of Group Plan: _____

Group Number: _____ Policy Number:_____

PERSON RESPONSIBLE FOR ACCOUNT (if different from above)

NAME: _____ Address: _____

Social Security #: _____

Home Phone #: _____ Business Phone #: _____

PERSON TO CONTACT OUTSIDE OF IMMEDIATE FAMILY

NAME: _____ TEL. #: _____

ADDRESS: _____

STREET CITY STATE ZIP

MEDICAL HEALTH HISTORY

Have you been a patient in the hospital during the past two years? _____ ☐yes ☐no

Nature of care: _____

Physician's Name: _____

Address: _____ Phone #: _____

Has a physician ever recommended antibiotics prior to dental or surgical exam? _____ ☐yes ☐no

Have you taken any medicine or drugs during the past two years? _____ ☐yes ☐no

List any medication(s) you are now taking. _____

_____

Are you allergic to or have you reacted adversely to any of the following medications?

(CIRCLE ANY WHICH APPLY)

Aspirin	Nitrous Oxide	Valium	Local Anesthetic (Novacaine or Xylocaine)
Darvon	Erythromycin	Scopolamine	Sleeping Pills (Nembutal/Seconal)
Codeine	Tetracycline	Penicillin	
Demerol	Percodan	Other Antibiotics	

Are you aware of being allergic to any other medications or substances? _____ ☐yes no

If yes, please list: _____

Circle any of the following which you have had or have at present:

Heart Failure
Heart Disease or Attack
Angina Pectoris
High Blood Pressure
Mitral Valve Prolapse
Rheumatic Fever
Congenital Heart Lesions
Scarlet Fever
Artificial Joints (Hips, Knee)
Anemia
Stroke
Kidney Trouble
Ulcers
Cosmetic Surgery
Artificial Heart Valve
Heart Pacemaker
Heart Surgery

Emphysema
Persistent Cough
Tuberculosis (TB)
Asthma
Hay Fever
Sinus Trouble
Allergies or Hives
Diabetes
Thyroid Disease
X-ray or Cobalt Treatment
Chemotherapy (Cancer, Leukemia)
Arthritis
Rheumatism
Cortisone Medicine
Glaucoma
A.I.D.S.

Hepatitis A (Infectious)
Hepatitis B (serum)
Liver Disease
Yellow Jaundice
Blood Transfusion
Drug Addiction
Hemophilia
Venereal Disease (Syphilis, Gonorrhea)
Cold Sores
Fever Blisters
Epilepsy or Seizures
Fainting or Dizzy Spells
Nervousness
Psychiatric Treatment
Sickle Cell Disease
Bruise Easily

When you walk up the stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? _____ ☐yes ☐no

Do your ankles swell during the day? _____ ☐yes ☐no

Do you use more than 2 pillows to sleep? _____ ☐yes ☐no

Do you ever wake up from sleep short of breath? _____ ☐yes ☐no

Are you on a special diet? _____ ☐yes ☐no

Has your medical doctor ever said you have a cancer or tumor? _____ ☐yes ☐no

Do you have any disease, condition, or problem not listed? _____ ☐yes ☐no

If yes, please list: _____

FOR WOMEN ONLY:

Are you pregnant? ☐yes ☐no If yes, list due date: _____

Are you taking birth control pills? ☐yes ☐no

COSMETIC HISTORY

Technological advances in dentistry have opened the door to wonderful new cosmetic options to improve your smile. With dedication to excellence, extensive continuing education, and constant training, our office has made the commitment to bring to our patients the best that cosmetic dentistry has to offer. If you have questions about how cosmetic dentistry can benefit you, please take a moment to answer the questions below.

Are you satisfied with your smile? ☐yes ☐no

If not, then how would you rate the appearance of your mouth? ☐Average ☐Below average ☐Poor

Check any of the following cosmetic improvements that you feel may be beneficial:

- ☐ Tooth Lightening or Whitening
- ☐ Straightening Crooked Teeth
- ☐ Smoothing/Reshaping Jagged or Worn Edges
- ☐ Tooth Lengthening or Shortening
- ☐ Replacing Missing Teeth
- ☐ Correcting Unsightly/Mismatched Teeth or Crowns
- ☐ Filling in Gaps Between Teeth
- ☐ Replacing Dark Fillings with Light Ones

Ask us about a Smile Makeover consultation.

DENTAL HEALTH HISTORY

MAIN PURPOSE FOR THIS VISIT: _____

Are you nervous about having dental treatment? _____ ☐yes ☐no

Have you ever had a bad experience in a dental office? _____ ☐yes ☐no

Do you have any pain in your teeth because of: ☐heat ☐cold ☐sweets ☐biting ☐chewing

Do you ever have mouth ulcers? ☐yes ☐no **Fever Blisters?** ☐yes ☐no

Do you have either now? ☐yes ☐no

Do you chew ice, popcorn kernels, or other hard food habitually? _____ ☐yes ☐no

Does food catch between your teeth? ☐yes ☐no **Where?** _____

Do you have a problem with your bite? ☐yes ☐no **Difficulty chewing?** ☐yes ☐no

Do you have facial tiredness or soreness while chewing? ☐yes ☐no **On awakening?** ☐yes ☐no

Do you frequently experience pain, clicking, or popping in your jaw joints? _____ ☐yes ☐no

Specify, including which side: _____

Do you ever clench your teeth during the day? ☐yes ☐no **At night?** ☐yes ☐no

Have you ever been treated for TMJ disorder? _____ ☐yes ☐no

Do your gums bleed when chewing, brushing, etc.? _____ ☐yes ☐no

Specify: _____

Are your gums now irritated, tender or swollen? _____ ☐yes ☐no

Has a dentist ever diagnosed gum disease in your mouth? _____ ☐yes ☐no

Do you go to the dentist regularly? _____ ☐yes ☐no

Your last exam and cleaning was within: (Check one) ☐ 6 mos. ☐ 1 yr. ☐ 2 yrs. ☐ 3-5 yrs. ☐ Longer

Have you ever had a panoramic or full-mouth series of x-rays made? _____ ☐yes ☐no

If yes, list approximate date made: _____/_____/_____

Do you brush your teeth VIGOROUSLY or LIGHTLY? (circle one) **How often do you brush?** _____

HARD or SOFT brush (circle one) **Do you avoid any part of the mouth while brushing?** ☐yes ☐no

Do you floss your teeth? ☐yes ☐no **How often?** _____

Have you ever had professional instructions on home care of teeth and gums? _____ ☐yes ☐no

Do you smoke? ☐yes ☐no **How often?** _____

Do you use smokeless tobacco products? _____ ☐yes ☐no

Would you like to discuss Vizilite® oral cancer screening? _____ ☐yes ☐no

Do you have an allergy to metals of any kind (jewelry, etc.)? _____ ☐yes ☐no

Specify: _____

Do you regularly use mouth mints? ☐yes ☐no **Gum?** _____ ☐yes ☐no

DENTAL SLEEP MEDICINE

Do you snore? ☐yes ☐no **Spouse?** ☐yes ☐no

Do you have excessive daytime sleepiness? ☐yes ☐no

Have you been diagnosed with sleep apnea? ☐yes ☐no

If yes, do you have any problems with your C-Pap? ☐yes ☐no

AUTHORIZATION

The undersigned hereby authorizes Dr. Dillon and/or Dr. Poole to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Dillon and/or Dr. Poole to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. Dillon and/or Dr. Poole to perform any and all forms of treatment, medication and therapy, that may be indicated and further authorize and consent that Dr. Dillon and/or Dr. Poole choose and employ such assistance as he deems fit. I understand that the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. If insurance is provided, I acknowledge your office will submit treatment information to my insurance company. I further understand that a 1 ½% finance charge (18% annually) will be added to any balance over 30 days. In the event of default I (we) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Note: As a courtesy to our patients, we will be glad to submit treatment information to your insurance company. Responsibility for payment of services, however, lies soley within the patient. Dental insurance is a contract between the insurance company and the insured, and does not involve this office. Any disputes regarding insurance benefits can only be resolved through your employer and your insurance company.

I HEREBY CERTIFY THAT ALL PREVIOUS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE

X_____ Date _____/_____/_____