Paulson DENTAL

Welcome

We would like to welcome you to our practice. Our goal is to help improve and maintain maximum oral health. Please fill out this form completely. Thank you for choosing us for your dental health care needs.

1 PERSONAL INFORMATION

Today's Date: _____

E-mail Address: _____

Name: _____
Last First Mi Mr Mrs Ms Dr

I prefer to be called: _____ ❑ Male ❑ Female

Birthday: ____/____/____ Age: _____ SS#: _____

Home Address: _____
Apt/Condo#

_____
City State Zip

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Home #: (____)_____ Pager/Cell #: (____) _____

Work #: (____)_____ Ext: _____ DL #: _____

Employer: _____

Employer's Address: _____

_____
City State Zip

How long there?: _____ Occupation: _____

Where & When are best times to reach you?: _____

Who may we thank for referring you?: _____

Other family members seen by us?: _____

Previous/Present Dentist: _____
(Please Circle)

Last visit date: _____

2 SPOUSE INFORMATION

His/Her Name: _____

Employer: _____

Work #: (____)_____ Ext: _____ SS #: _____

Birthday: ____/____/____ DL#: _____

Person responsible for account:

Name: _____
Last First Mi Mr Mrs Ms Dr

Work #: (____)_____ Ext: _____ Hm #: (____)_____

Billing Address: _____

_____
City State Zip

Relationship: _____ SS#: _____

Employer: _____ DL#: _____

3 INSURANCE

Primary Insurance

Dental Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____)_____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthday: ____/____/____ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

Secondary Insurance

Dental Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____)_____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthday: ____/____/____ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

Neighbor or relative not living with you

His/Her Name: _____ Relation: _____

Work #: (____)_____ Hm #: (____) _____

Address: _____

_____
City State Zip

4 DENTAL HISTORY

Why have you come to the dentist today?

Do you require antibiotics before dental cleaning? ❑ Yes ❑ No

Are you currently in pain? ❑ Yes ❑ No

Have you ever had a serious/difficult problem associated with any previous dental work? ❑ Yes ❑ No

Do you have fears about going to the dentist? ❑ Yes ❑ No

Do you now have or ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ❑ **Yes** ❑ **No**

Your current dental health is ❑ Good ❑ Fair ❑ Poor

Do you like your smile? ❑ Y ❑ N Do your gums ever bleed? ❑ Y ❑ N

How many times a week do you floss? _____ Times a day do you brush? _____

Type of bristles? ❑ Soft ❑ Medium ❑ Hard

How long do you use a toothbrush before replacing it?

Are your teeth sensitive to heat, cold, or anything else?

Have you lost any teeth? ❑ Y ❑ N If yes why? _____

CONTINUED ON BACK

5 MEDICAL HISTORY

Do you have a personal Physician?: ❑ Yes ❑ No

Physician's Name: _____

Work #: (_____)_____ Date of last visit: _____

Are you currently under the care of a physician?: ❑ Yes ❑ No

Please explain: _____

Current Medications

_____

_____

_____

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

Y N Aspirin _____
Y N Barbiturates, sedatives, or sleeping pills _____
Y N Codeine or other narcotics _____
Y N Iodine _____
Y N Latex (rubber) _____
Y N Local anesthetics _____
Y N Metals _____
Y N Penicillin or other antibiotics _____
Y N Sulfa Drugs _____
Y N Other _____

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

Do you smoke or use tobacco in any form? ❑ Y ❑ N
Have you had any metal rods, pins or implants? ❑ Y ❑ N
Are you taking prescription/over-the-counter or herbal supplemental drugs? ❑ Y ❑ N
Please list each one:
Have you ever taken Fosomax, or any bisphosphonate? ❑ Y ❑ N
Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath? ❑ Y ❑ N

Joint Replacement.

Y N Have you had total joint replacement? (hip, knee, elbow, finger)
Date: _____ If yes, have you had any complications? _____

Y N Are you taking or scheduled to begin taking an antiresorptive agent (like Fosomax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease?

Y N Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?
Date treatment began: _____

Have you ever had any of the following diseases or medical problems

Y N Artificial (prosthetic) heart valve
Y N Congenital heart disease (CHD)
  Y N Unrepaired, cyanotic CHD
  Y N Repaired (completely) in the last 6 months
  Y N Repaired CHD with residual defects
Y N Damaged valves in transplanted heart
Y N Previous infective endocarditis

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

Y N Abnormal bleeding
Y N AIDS or HIV infection
Y N Anemia
Y N Angina
Y N Arteriosclerosis
Y N Arthritis
Y N Asthma
Y N Autoimmune disease
Y N Blood transfusion
  If yes, date: _____
Y N Bronchitis
Y N Cancer/Chemotherapy/ Radiation treatments
Y N Cardiovascular disease
Y N Chest Pain upon exertion
Y N Chronic pain
Y N Congestive heart failure
Y N Damaged heart valves
Y N Diabetes Type I and II
Y N Do you snore?
Y N Eating disorder
Y N Emphysema
Y N Epilepsy
Y N Excessive urination
Y N Fainting spells or seizures
Y N Gastrointestinal disease
Y N G.E. Reflux/persistent heartburn
Y N Glaucoma
Y N Heart attack
Y N Heart murmur
Y N Hepatitis, Jaundice or Liver disease
Y N Hemophillia
Y N High blood pressure
Y N Kidney problems
Y N Low blood pressure
Y N Malnutrition
Y N Mental health disorders
  Specify:_____
Y N Mitral valve prolapse
Y N Neurological disorders
  If yes, specify: _____
Y N Osteoporosis
Y N Other congenital heart defects
Y N Pacemaker
Y N Persistant swollen glands in neck
Y N Recurrent Infections
  Type of infection: _____
Y N Rheumatic fever/Scarlet
Y N Rheumatic heart disease
Y N Rheumatiod arthritis
Y N Severe headaches/migraines
Y N Severe or rapid weight loss
Y N Sexually transmitted disease
Y N Sinus trouble
Y N Sleep disorder
Y N Stroke
Y N Systemic lupus erythematosus
Y N Thyriod problems
Y N Tuberculosis
Y N Ulcers

Y N Do you have any disease, condition, or problem not listed above that you think I should know about?
Please explain: _____

Payment is due in full at the time of treatment unless prior arrangements have been approved.
If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby autherize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

NOTE: Patients are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member if her staff, responsible for any action they take or do not take because of errors or omissions that I have made in the completion of this form.

I have received a copy of this office's Notice of Privacy Practices.

Signature of Patient/Legal Guardian _____ Date _____

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.