BEAR TOOTH DENTAL

•WELCOME•

To help us meet all your healthcare needs, please fill out this form completely. If you have any questions about this form, please ask and we will be happy to help.

Patient Information (Confidential)

Last Name_____ First Name_____ M.I.____ Preferred Name_____

Address_____ City_____ State_____ Zip_____

Best Phone Number for our office to reach you?_____

SSN_____-_____-_____ DOB_____/_____/_____ Sex M F

Marital Status: S M D W Other Email Address_____

If Student, Name of School/College_____ Full Time_____ Part Time_____

Patient's Employer_____ Occupation_____

Spouse's Name_____ Employer_____

Person to contact in case of emergency_____ Phone Number(____)_____

Which payment method do you prefer? Cash_____ Check_____ Visa/MasterCard_____

How did you hear about our office?_____

Primary Insurance Information

Name of Insured_____ Relationship to Patient_____ DOB____/____/____ SSN_____-____-_____

Insurance Company_____ Group #_____ Phone #_____

Do you have secondary insurance? Yes_____ No_____

2nd Insured's Name_____ Relationship to Patient_____ DOB____/____/____ SSN_____-____-_____

Insurance Company_____ Group #_____ Phone #_____

Patient Dental History

Reason for today's visit_____Previous Dentist_____

Date of last dental x-rays_____/_____ Date of last dental visit_____/_____

1. Do your gums bleed while brushing/flossing? Yes No
2. Are your teeth sensitive to hot/cold liquids/foods? Yes No
3. Are your teeth sensitive to sweet/sour liquids/foods? Yes No
4. Do you feel pain in any of your teeth? Yes No
5. Do you have any sores or lumps in or near your mouth? Yes No
6. Have you had any head, neck or jaw injuries? Yes No
7. Have you ever experienced any of the following problems in your jaw?
   Clicking Yes No
   Pain/Difficulty in opening or closing your mouth? Yes No
8. Do you have frequent headaches? Yes No
9. Do you clench or grind your teeth? Yes No
10. Does dental treatment make you nervous? Yes No
11. Have you had any difficult extractions? Yes No
12. Do you have bad breath? Yes No
13. Have you had any orthodontic treatment? Yes No
14. Do you wear dentures or partials? Yes No
    If yes, date of placement?_____/_____/_____
15. Are you satisfied with the appearance of your teeth? Yes No
16. Would you like a whiter smile? Yes No

Patient Medical History

Physician_____ **Date of Last Exam**_____/_____

1. Are you under medical treatment now? Yes_____ No_____
   If yes, please explain_____
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 2 years? Yes_____ No_____
   If yes, please explain_____
3. Are you currently taking any medication(s) including non-prescription medicine? Yes_____ No_____
   If yes, please explain_____
4. Do you use any tobacco products? Yes_____ No_____
5. Are you allergic to or have you had any reactions to the following?

Aspirin	Yes____	No____
Latex Rubber	Yes____	No____
Local Anesthetics (ex. Lidocaine)	Yes____	No____
Any Metals (ex. Nickel, mercury, etc.)	Yes____	No____
Penicillin or any other antibiotics	Yes____	No____
Sedatives	Yes____	No____
Sulfa Drugs	Yes____	No____

Other_____

6. Are you taking any blood thinners? Yes____ No___
7. Do you have a persistent cough or throat clearing not associated with a known illness? Yes____ No____

Women Only:

1. Are you pregnant or do you think you might be? Yes____ No____
2. Are you nursing? Yes____ No_____
3. Are you taking oral contraceptives? Yes____ No___

Please circle if you currently have or have had any of the following:

ANEMIA	DIABETES	HEPATITIS	RADIATION TREATMENT
ANGINA	DIZZINESS	HIGH/LOW BLOOD PRESSURE	RECENT WEIGHT LOSS
ARTHRITIS	EMPHYSEMA	HIV	RESPIRATORY PROBLEMS
ASTHMA	EPILEPSY/CONVULSIONS	JOINT REPLACEMENT	RHEUMATIC FEVER
AUTOIMMUNE DISEASE	EXCESSIVE BLEEDING	KIDNEY DISEASE	SINUS PROBLEMS
BLOOD DISEASE	FAINTING/SEIZURES	LEUKEMIA	STOMACH PROBLEMS/ULCER
CANCER	GLAUCOMA	LIVER DISEASE	STROKE
CARDIAC PACEMAKER	HEAD INJURIES	MENTAL DISORDER	THYROID PROBLEMS
CHEMOTHERAPY	HEART DISEASE/ATTACK	MITRAL VALVE PROLAPSE	TUBERCULOSIS
	HEART MURMUR	NERVOUS DISORDER	OTHER_____

Authorization & Release/Consent for Treatment

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me.

a. I authorize the doctor or his/her staff to take x-rays, photographs, make models, or conduct other tests deemed necessary in order to make a thorough diagnosis by the doctor.
b. After making such diagnosis, I give permission to undertake the recommended treatment plan that has been mutually agreed upon.
c. I agree to the use of anesthetics and other medication as necessary, and further understand that these may carry certain risks. I understand that I may ask the doctor for a complete listing of possible complications.

Patient's Signature_____ Date_____/_____/_____