PATIENT INFORMATION

First Name _____ Middle Initial _____ Last Name _____

Preferred Name _____ Patient is: ☐ Policy Holder ☐ Responsible Party

Address _____ City _____ State _____ Zip: _____

Home Phone _____ Mobile Phone _____ Work Phone _____

Please rank the best way to confirm appointments (1-4, 1 being the best) Cell ____ Home ____ E-Mail ____ Text _____

Sex: ☐ M ☐ F Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widow

Birth Date _____/_____/_____ Age _____ Social Security # _____ Driver's Lic # _____

Employer _____ Occupation _____ Rank (if military) _____

*Email Address _____ *We respect your privacy. We do not give out your information.

Our office requests email information in order to send appointment reminders, birthday wishes, and newly published dental information.

Referred By: ○ Website ○ Google ○ Insurance ○ Phone Book ○ Other _____ ○ *Friend/Family _____

*We have a referral program that benefit our referring patients

RESPONSIBLE PARTY (If Someone Other than Yourself)

First Name _____ Middle Initial _____ Last Name _____

Address _____ City _____ State _____ Zip: _____

Home Phone _____ Mobile Phone _____ Work Phone _____

Birth Date _____/_____/_____ Age _____ Social Security # _____ Driver's Lic # _____

Employer _____ Occupation _____ Rank (if military) _____

*PRIMARY INSURANCE INFORMATION

Name of Policy Holder _____ ○ Self ○ Spouse ○ Child ○ Other

Insured SS#/ID# _____ Insured Birth Date _____

Employer _____ Insurance Company _____ Group # _____

Ins. Phone # _____Billing Address _____

*SECONDARY INSURANCE INFORMATION

Name of Policy Holder_____ ○ Self ○ Spouse ○ Child ○ Other

Insured SS#/ID# _____ Insured Birth Date _____

Employer _____ Insurance Company _____ Group # _____

Ins. Phone # _____Billing Address _____

*Insurance is a contract between you and your insurance company. SRFD does not have a say in your plan benefits. We will bill your insurance company as a courtesy to you and we will do our best to collect what is rightfully your benefit. Although we may **ESTIMATE** what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. It is your responsibility to know your insurance benefits, not ours. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. INSURANCE IS NOT A GUARANTEE OF PAYMENT. YOU AGREE TO PAY ANY PORTION OF THE CHARGES NOT COVERED BY INSURANCE. ANY INSURANCE CLAIM THAT HAS NOT BEEN PAID WITHIN 4 WEEKS BECOMES YOUR RESPONSIBILITY FOR PROMPT PAYMENT. TO AVOID THIS, PLEASE MAKE SURE YOU ARE IN CONTACT WITH YOUR INSURANCE COMPANY REGARDING THE UNPAID CLAIMS AFTER 4 WEEKS. WE DO NOT FILE SECONDARY INSURANCE. You agree to notify SRFD of any changes with your dental insurance as soon as possible and NOT the day of your child's appointment.

MEDICAL HISTORY

Your teeth, mouth, and oral health are all linked to your medical health or any medication that you may be taking; therefore, we ask that you fill out the medical history to the best of your knowledge.

Are you under a physician's care now?	○ Yes	○ No	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	○ Yes	○ No	If yes, please explain: _____
Have you had a problem with general anesthesia?	○ Yes	○ No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	○ Yes	○ No	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	○ Yes	○ No	If yes, please explain: _____
Do you use tobacco?	○ Yes	○ No	If yes, please explain: _____
Do you use controlled substances?	○ Yes	○ No	If yes, please explain: _____

Women: Are you ○ Pregnant/Trying to get pregnant? ○ Nursing ○ Taking Oral Contraceptives

Are you allergic to any of the following? ○ Aspirin ○ Penicillin ○ Codeine ○ Acrylic ○ Metal ○ Latex ○ Local Anesthetics ○ Other

If yes, please explain: _____

Do you have, or have you had any of the following? ○ YES (please indicate below) ○ NO

○ Aids/HIV	○ Chest Pains	○ Frequent Headaches	○ Irregular Heartbeat	○ Scarlet Fever
○ Alzheimer's Disease	○ Cold Sores/Fever Blisters	○ Genital herpes	○ Kidney Problems	○ Shingles
○ Anaphylaxis	○ Congenital Heart Disorder	○ Glaucoma	○ Leukemia	○ Sickle Cell Disease
○ Anemia	○ Convulsions	○ Hay Fever	○ Liver Disease	○ Sinus Trouble
○ Angina	○ Cortisone Medicine	○ Heart Attack/Failure	○ Low Blood Pressure	○ Spina Bifida
○ Arthritis/Gout	○ Diabetes	○ Heart Murmur	○ Lung Disease	○ Stomach/Intestinal Disease
○ Artificial Heart Valve	○ Drug Addiction	○ Heart Pace Maker	○ Mitral Valve Prolapse	○ Stroke
○ Artificial Joint	○ Easily Winded	○ Heart Trouble/Disease	○ Pain in Jaw Joints	○ Swelling of Limbs
○ Asthma	○ Emphysema	○ Hemophilia	○ Parathyroid Disease	○ Thyroid Disease
○ Blood Disease	○ Epilepsy or Seizures	○ Hepatitis A	○ Psychiatric Care	○ Tonsilitis
○ Blood Transfusion	○ Excessive Bleeding	○ Hepatitis B or C	○ Radiation Treatments	○ Tuberculosis
○ Breathing Problem	○ Excessive Thirst	○ Herpes	○ Recent Weight Loss	○ Tumors or Growths
○ Bruise Easily	○ Fainting Spells/Dizziness	○ High Blood Pressure	○ Renal Dialysis	○ Ulcers
○ Cancer	○ Frequent Cough	○ Hives or Rash	○ Rheumatic Fever	○ Venereal Disease
○ Chemotherapy	○ Frequent Diarrhea	○ Hypogylcemia	○ Rheumatism	○ Yellow Jaundice

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes, please explain _____

Comments:

_____

_____

_____

_____

I have answered all the questions on this form to the best of my knowledge. I understand that any false information can be dangerous to my health. I also understand that it is my responsibility to notify Star Ranch Family Dental of any changes in my medical status.

Name (Printed) _____

Signature of Patient _____ Date _____

Witness _____ Date _____

StarRanch FAMILY DENTAL

DENTAL HISTORY

Reason for this visit _____

Many patients get second opinions. Are you currently seeing another dentist? ○ Yes ○ No

Do you have a specific dental problem? ○ Yes ○ No If yes, please describe _____

How would you describe the condition of your teeth and gums? ○ Good ○ Fair ○ Poor

When was your last dental visit? _____ Previous Dentist Name _____ Location _____

YOUR SMILE

Do you like your smile? ○ Yes ○ No If no, please explain _____

If you could change one thing about your teeth/smile, what would you change? _____

Are you interested in whitening your teeth? ○ Yes ○ No

DENTAL HYGIENE

What type of toothbrush do you use? ○ Soft ○ Medium ○ Hard ○ Electric

How often do you brush your teeth? _____ How often do you floss your teeth? _____

Do you drink fluoridated water? ○ Yes ○ No

Do your gums bleed when you brush? ○ Yes ○ No

Do your gums bleed when you floss? ○ Yes ○ No

Are your teeth sensitive to hot or cold? ○ Yes ○ No

Are your teeth sensitive to sour foods/liquids? ○ Yes ○ No

PERIO

Do you have pain when biting or chewing? ○ Yes ○ No If yes, please explain: _____

Do you bite your cheek or lips often? ○ Yes ○ No If yes, please explain:_____

Have you ever been diagnosed with periodontitis? ○ Yes ○ No If yes, please explain: _____

Have you noticed any loosening of your teeth? ○ Yes ○ No If yes, please explain: _____

Does food get caught between your teeth? ○ Yes ○ No If yes, please explain: _____

TMJ/JAW

Have you had any head, neck, or jaw injuries? ○ Yes ○ No If yes, please explain: _____

Do you have clicking when opening/closing? ○ Yes ○ No

Do you have pain in the jaw joint? ○ Yes ○ No If yes, please explain: _____

Do you have frequent headaches? ○ Yes ○ No If yes, please explain:_____

Do you grind your teeth? ○ Yes ○ No

Do you clench your teeth? ○ Yes ○ No

SLEEPING HABITS

Do you feel tired when you wake up in the morning? ○ Yes ○ No If yes, please explain: _____

Do you snore or has someone told you that you snore? ○ Yes ○ No If yes, please explain: _____

ORAL LESIONS

Have you noticed any strange sores/bumps in your mouth? ○ Yes ○ No If yes, please explain:_____

MISCELLANEOUS

Have you ever had……

Orthodontic treatment (braces) ○ Yes ○ No

Your teeth ground or your bite adjusted? ○ Yes ○ No

Worn a night/mouth guard or other appliance? ○ Yes ○ No If yes, what appliance? _____

Gum surgery? ○ Yes ○ No

Oral surgery? ○ Yes ○ No If yes, did you have prolonged bleeding? ○ Yes ○ No

Please initial that the above questions were answered to the best of your knowledge _____