SPECTRUM DENTAL

Name_____ Mr. Mrs. Miss Dr. Today's Date_____

SS#_____ If Minor, Parent's Name_____

Date of Birth_____ Age_____ Sex M F

Address_____

City_____ State_____Zip Code_____

Home Phone_____Cell Phone_____E-mail_____

Occupation_____ Employed By_____

Marital Status (circle) M S W D Spouse's Name_____

Spouse's Occupation_____Employed By_____

Person Responsible for This Account_____

Whom may we thank for referring you?_____

Form of payment: { } CASH { } CREDIT CARD { } CHECK { } INSURANCE

As a benefit to our patients, we submit insurance. However, patient portion is due at time services are rendered.

INSURANCE

Primary Insurance Company_____Group Plan_____Group # _____

Address_____ Phone #_____

Policyholder_____ SS#_____Date of Birth_____

Secondary Insurance Company_____Group Plan_____Group #_____

Address_____ Phone #_____

Policyholder_____ SS#_____ Date of Birth_____

DENTAL HISTORY

Purpose of your visit?_____

Have you had any problems with previous dental treatment?_____

_____

Check if you have had problems with the following:

- ❑ Bad taste in your mouth
- ❑ Bad odor in your mouth
- ❑ Discomfort in head or face
- ❑ Grinding your teeth
- ❑ Loose teeth
- ❑ Broken fillings
- ❑ Periodontal treatment
- ❑ Sensitive to hot, cold
- ❑ Sensitive to biting
- ❑ Bleeding Gums
- ❑ Clicking or popping of jaw
- ❑ Swelling or bumps
- ❑ Food collecting between teeth

Are you dissatisfied with your teeth and their appearance? YES NO
Do you feel that in the past you have required a lot of dental work? YES NO
Do any of your family members wear dentures? YES NO
Do you feel you will eventually lose teeth and wear dentures? YES NO

OVER

CONFIDENTIAL MEDICAL HISTORY

Physician's Name_____ Date of last visit_____

Have you been hospitalized in the last 2 years? If yes, please explain_____

_____

MEDICATIONS

List your current medications_____

_____

Check if you have allergic reactions to any of the following:

- ❑ Aspirin
- ❑ Penicillin
- ❑ Barbiturates
- ❑ Codeine
- ❑ Sulfa
- ❑ Anesthetics
- ❑ Latex
- ❑ Other_____

Check if you have or have had any of the following:

- ❑ Aids
- ❑ Cortisone treatments
- ❑ Heart attack
- ❑ Angina
- ❑ Artificial valves
- ❑ Heart murmur
- ❑ Anemia
- ❑ Arthritis
- ❑ Artificial joints
- ❑ Asthma
- ❑ Back Problems
- ❑ Blood disease
- ❑ Cancer
- ❑ Chemical dependency
- ❑ Persistent cough
- ❑ Cough up blood
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Glaucoma
- ❑ Headaches
- ❑ Circulatory problems
- ❑ Hepatitis
- ❑ HIV positive
- ❑ High blood pressure
- ❑ Jaundice
- ❑ Kidney disease
- ❑ Mitral valve prolapse
- ❑ Chemotherapy
- ❑ Nervous problems
- ❑ Pacemaker
- ❑ Psychiatric care
- ❑ Radiation treatment
- ❑ Respiratory disease
- ❑ Rheumatic fever
- ❑ Scarlet fever
- ❑ Shortness breath
- ❑ Sinus problems
- ❑ Stroke
- ❑ Skin rash
- ❑ Swelling feet, glands
- ❑ Thyroid problems
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Venereal disease

Please list any serious operations you have had?_____

Have you ever had a serious accident?_____

Have you ever had bleeding or other problems following dental treatment?_____

_____

Do injuries and cuts take longer than 2 weeks to heal? YES NO

Do you pre medicate before dental appointments? YES NO

Women Only*

*Are you Pregnant? YES / NO *Nursing? YES / NO *Taking Birth Control? YES / NO *Have osteoporosis? YES / NO

CONSENT

The information on both pages is correct, to the best of my knowledge. I give my consent to have the necessary treatment recommended for my (or my minor's) dental needs, after it has been mutually approved. I will not hold my dentist or his/her staff liable for any errors that I may have made while completing this form. I understand that my insurance policy is an agreement between my insurance company and myself. I am aware that I will be responsible for any fees not covered by my insurance plan.

DATE_____PATIENT SIGNATURE_____

DATE_____SIGNATURE_____