

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

INSURANCE

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

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:

- | | | |
|---|---|--|
| <input type="checkbox"/> Bad taste in your mouth | <input type="checkbox"/> Broken fillings | <input type="checkbox"/> Bleeding Gums |
| <input type="checkbox"/> Bad odor in your mouth | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Clicking or popping of jaw |
| <input type="checkbox"/> Discomfort in head or face | <input type="checkbox"/> Sensitive to hot, cold | <input type="checkbox"/> Swelling or bumps |
| <input type="checkbox"/> Grinding your teeth | <input type="checkbox"/> Sensitive to biting | <input type="checkbox"/> Food collecting between teeth |
| <input type="checkbox"/> Loose teeth | | |

Are you dissatisfied with your teeth and their appearance?

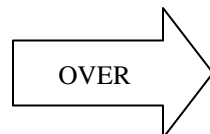
Do you feel that in the past you have required a lot of dental work?

Do any of your family members wear dentures?

Do you feel you will eventually lose teeth and wear dentures?

YES NO
YES NO
YES NO
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:

- | | | |
|---------------------------------------|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Sulfa | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Anesthetics | _____ |
| <input type="checkbox"/> Barbiturates | <input type="checkbox"/> Latex | _____ |
| <input type="checkbox"/> Codeine | | |

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

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

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 _____