

# Welcome To Atkinson Dental Clinic

*“We Cater to Cowards & Children”*

## 1 About You

Today's Date:
Name:
I prefer to be called:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth:
Social Security Number:
Home Address:
City:                      State:                      Zip:
Marital Status:
Home Phone:
Work Phone:                                      Ext:
Employer:
Occupation:
Whom may we thank for referring you? Other family members seen by us:
Would you like to receive your dental checkup reminder by email? <input type="checkbox"/> Yes <input type="checkbox"/> No
Email Address:

## 2 Spouse Information

Name:
Date of Birth:
Social Security Number:
Work Phone:                                      Ext:
Employer:
Occupation:

## 3 Insurance

<b>PRIMARY INSURANCE</b>
Insurance Company:
Claims Address:
City:                      State:                      Zip:
Ins. Co. Phone#:
Group#:
Name of Insured:
Relationship to Patient:
Social Security # of Insured:
Birth Date of Insured:
Name of Insured's Employer:
<b>SECONDARY INSURANCE</b>
Insurance Company:
Claims Address:
City:                      State:                      Zip:
Ins. Co. Phone#:
Group#:
Name of Insured:
Relationship to Patient:
Social Security # of Insured:
Birth Date of Insured:
Name of Insured's Employer:

## 4 In Case of Emergency

Please provide the following for a friend or relative not living with you:
Name:
Relationship to You:
Home Phone Number:
Work Phone Number:

**Form Continued on Back**

## 5 Medical History

Name of Medical Doctor: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Date of Last Visit to Medical Doctor: \_\_\_\_\_

Current Health Status:  Good  Fair  Poor

Are You Taking Any of the Following? (Check all that apply)

- |   |   |
|---|---|
| <input type="checkbox"/> Acetaminophen  | <input type="checkbox"/> Heart Medication         |
| <input type="checkbox"/> Antibiotics    | <input type="checkbox"/> Insulin                  |
| <input type="checkbox"/> Antihistamines | <input type="checkbox"/> Oral Diabetes Medication |
| <input type="checkbox"/> Aspirin        | <input type="checkbox"/> Antidepressants          |
| <input type="checkbox"/> Blood Thinner  | <input type="checkbox"/> Steroids                 |
| <input type="checkbox"/> Tranquilizers  | <input type="checkbox"/> Blood Pressure Medicine  |
| <input type="checkbox"/> Nitroglycerine | <input type="checkbox"/> Thyroid Medication       |

Do you have a medical condition that requires you to take antibiotics before receiving dental treatment?  Yes  No

Have you ever been diagnosed with or treated for any of the following conditions? (Check all that apply)

- |   |   |
|---|---|
| <input type="checkbox"/> Abnormal Bleeding          | <input type="checkbox"/> Heart Attack           |
| <input type="checkbox"/> Artificial Bones/Joints    | <input type="checkbox"/> Heart Murmur           |
| <input type="checkbox"/> Artificial Heart Valves    | <input type="checkbox"/> Mitral Valve Prolapse  |
| <input type="checkbox"/> Alcohol Abuse              | <input type="checkbox"/> Hemophilia             |
| <input type="checkbox"/> Asthma                     | <input type="checkbox"/> Hepatitis              |
| <input type="checkbox"/> Cancer                     | <input type="checkbox"/> HIV / AIDS             |
| <input type="checkbox"/> Congenital Heart Defect    | <input type="checkbox"/> Kidney Problems        |
| <input type="checkbox"/> Diabetes (takes insulin)   | <input type="checkbox"/> Low Blood Pressure     |
| <input type="checkbox"/> Diabetes (takes oral meds) | <input type="checkbox"/> Psychiatric Problems   |
| <input type="checkbox"/> Drug Abuse                 | <input type="checkbox"/> Tuberculosis           |
| <input type="checkbox"/> Emphysema                  | <input type="checkbox"/> Non-Epileptic Seizures |
| <input type="checkbox"/> Epilepsy                   | <input type="checkbox"/> Glaucoma               |
| <input type="checkbox"/> Fainting Spells            | <input type="checkbox"/> Rheumatic Fever        |
| <input type="checkbox"/> Scarlet Fever              | <input type="checkbox"/> Anxiety Attacks        |
| <input type="checkbox"/> Shortness of Breath        | <input type="checkbox"/> Lupus                  |

Please list any other serious medical conditions you have or have had in the past: \_\_\_\_\_

Have you ever received any of the following medical treatments? (Check all that apply)

- |                                       |   |
|---------------------------------------|---|
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> I wear a Pacemaker |
| <input type="checkbox"/> Radiation    | <input type="checkbox"/> Open Heart Surgery |

Are you allergic to any of the following? (Check all that apply)

- |                                       |   |
|---------------------------------------|---|
| <input type="checkbox"/> Penicillin   | <input type="checkbox"/> Tetracycline       |
| <input type="checkbox"/> Aspirin      | <input type="checkbox"/> Latex              |
| <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Codeine            |
| <input type="checkbox"/> Sulfa Drugs  | <input type="checkbox"/> Sedatives          |
| <input type="checkbox"/> Keflex       | <input type="checkbox"/> Nitrous Oxide      |
| <input type="checkbox"/> Metals       | <input type="checkbox"/> Dental Anesthetics |

Other: \_\_\_\_\_

For Women:

- Are you taking birth control pills?  Yes  No
- Are you pregnant?  Yes (week# \_\_\_\_\_)  No
- Are you nursing?  Yes  No

## 6 Dental History

Why have you come to the dentist today? \_\_\_\_\_

Do you floss daily?  Yes  No

Do you brush daily?  Yes  No

Type of bristles on your toothbrush:

- Hard  Medium  Soft

How often do you replace your toothbrush? \_\_\_\_\_

Do you use anything in addition to a brush and floss?

- Yes  No If yes, what? \_\_\_\_\_

Do your gums ever bleed?  Yes  No

Have you ever been told you have periodontal disease?

- Yes  No If yes, when? \_\_\_\_\_

Are your teeth sensitive to any of the following?

- Heat  Cold  Sweet  Pressure

Do you experience discomfort in your jaws (TMJ/TMD)?

- Yes  No

Previous Dentist: \_\_\_\_\_

Date of Last Visit: \_\_\_\_\_

Reason for leaving last dentist: \_\_\_\_\_

What qualities do you like most in a dentist? \_\_\_\_\_

What qualities do you like least? \_\_\_\_\_

Are you happy with the way your smile looks?

- Yes  No If no, why not? \_\_\_\_\_

Is snoring a problem for you or your spouse?  Yes  No

Would you like whiter teeth?  Yes  No

## 7 Authorization

I affirm that the information I have given on this form is correct to the best of my knowledge and it is my responsibility to inform this office of any changes in my medical status. I authorize my insurance benefits be paid directly to Atkinson Dental Clinic and I understand that I am responsible for the payment of deductibles, co-payments, and any balances not covered by my insurance. I also authorize Atkinson Dental Clinic to release any information required to process my claims. I understand that payment is due at the time of service.

Signature \_\_\_\_\_

Date \_\_\_\_\_