PEAKDENTAL
COSMETIC & FAMILY DENTISTRY

PATIENT INFORMATION

Name : _____ Date of Birth: _____

Preferred Name : _____ SSN : _____

Email Address : _____

How did you hear about us? _____

Street Address : _____ City/State/Zip _____

Cell Phone: _____ Work Phone: _____

Preferred Pharmacy: _____ Pharmacy Phone: _____

PLEASE NOTE: *By providing the above contact information, you agree that the information is correct, and you agree for our office to utilize this information to contact you regarding any communication.*

Emergency Contact Person: _____

Relation: _____ Phone #: _____

By listing a contact person about you agree for our office to disclose any and all pertinent information regarding your care to person listed above in the event of an emergency.

DENTAL INSURANCE SUBSCRIBER

Name: _____ Date of Birth: _____

Employer: _____ SSN: _____

Dental Insurance: _____ Policy/Subscriber #: _____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ DL#: _____

Signature _____ Date: _____

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I understand I and solely responsible for any balances not paid by my insurance company.

DENTAL AND HEALTH HISTORY

Reason(s) for today's visit: ____ New Patient ____ Emergency (Are you in pain? - Y / N)

If yes, how long? _____

Are you you having any of the following problems: *(circle all that apply)*

Bad breath / Blisters / Sores / Discomfort, clicking, popping in jaw / Locking jaw

Red, swollen, bleeding gums / Sensitive teeth or gums / Stained Teeth / Teeth grinding

Broken or lost: Fillings / Broken or chipped: Teeth

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DENTAL AND HEALTH HISTORY CONTINUED

What type of toothbrush do you use? ____ Soft ____ Medium ____ Hard

How many times a day do you brush? _____ How many times a week do you floss? _____

What would you like to change about your smile? _____

How would you rate your smile? 1 2 3 4 5 6 7 8 9 10

Previous Dentist: _____ Date of last exam: _____

Medical Doctor: _____ Phone Number: _____

Are you taking any medications or supplements? **Yes** or **No** if yes, please list the names:

_____

_____

Are you currently taking any **BLOOD THINNERS** (including Aspirin, Plavix, Coumadin, Xareltor, Brilinta)

Yes or **No** If yes, what?_____

Do you have or have you had any of the following?

YES	NO		YES	NO		YES	NO	
☐	☐	Alcohol/Drug Abuse	☐	☐	Emphysema	☐	☐	Mitral Valve Prolapse
☐	☐	Anemia	☐	☐	Glaucoma	☐	☐	Nervousness
☐	☐	Arthritis/Rheumatism	☐	☐	Heart Attack/Stroke	☐	☐	Pacemaker
☐	☐	Artificial Valves	☐	☐	Heart Disease	☐	☐	Psychiatric Problems
☐	☐	Asthma/Difficulty Breathing	☐	☐	Heart Murmur	☐	☐	Respiratory Problems
			☐	☐	Heart Surgery	☐	☐	Rheumatic Fever
☐	☐	Back Problems	☐	☐	Hepatitis	☐	☐	Scarlet Fever
☐	☐	Bleeding Problems	☐	☐	High/Low Blood Pressure	☐	☐	Seizures/Fainting
☐	☐	Cancer	☐	☐	HIV+/AIDS/ARC	☐	☐	Shingles
☐	☐	Chemotherapy	☐	☐	Jaw Problems	☐	☐	Stomach Problems
☐	☐	Chest Pains	☐	☐	Kidney Problems	☐	☐	Thyroid Problems
☐	☐	Congenital Heart Disease	☐	☐	Leukemia	☐	☐	Tuberculosis (TB)
☐	☐	Cosmetic Surgery	☐	☐	Liver Problems	☐	☐	Veneral Disease
☐	☐	Diabetes/Hypoglycemia	☐	☐	Migraines/Headaches			

Text

Please list any other ***medical conditions*** or ***surgeries*** you have had_____

_____

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

Penicillin **Amoxicillin** **Tetracycline** **Local Anesthetic**

Codeine **Latex** **Sulfa** **Other** _____

Do you use tobacco products? **Yes** or **No** How many packs/day and how long? _____

Rate your general health 1 2 3 4 5 6 7 8 9 10

WOMEN ONLY Are you pregnant? **Yes** or **No** If yes, how many weeks? _____

Are you nursing? **Yes** or **No** Do you take birth control or hormone pills? **Yes** or **No**