Scott Family Dental

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create,receive, or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

PATIENT INFORMATION

Today's Date: _____

Patient's name (First, Middle Initial, Last): _____ Suffix: _____

If minor, name is parent/ legal guardian: _____

Birthdate: _____/_____/_____ Age: _____

Home phone (____)_____ Business/ Cell Phone (____)_____ *Please Circle Preferred Contact #*

Mailing Address _____ City _____State _____ Zip _____

Social Security Number: _____

Employer _____ Occupation _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Long-Term Partner

Spouse's name _____ Spouse's employer _____

Spouse/Partner Social Security Number: _____ Spouse/Partner Birthdate: _____/_____/_____

Emergency Contact and Phone Number: _____ Relationship: _____

Whom may we thank for referring you to our office? _____

❑ Phonebook ❑ Website ❑ Magazine Advertisement ❑ Friend/ Family ❑ Other

Other Family Members Seen By Us: _____

DENTAL INSURANCE INFORMATION

BILLING, CREDIT, AND INSURANCE INFORMATION: ❑ Not covered by dental insurance

PRIMARY DENTAL INSURANCE

Dental Insurance Company Name:_____ Group number (Plan, Local, or Policy #):_____

Insured's Name:_____ Relation:_____

Insured's Birthdate: _____/_____/ _____ Insured's Employer: _____

SECONDARY DENTAL INSURANCE

Dental Insurance Company Name:_____ Group number (Plan, Local, or Policy #):_____

Insured's Name:_____ Relation:_____

Insured's Birthdate: _____/_____/ _____ Insured's Employer: _____

Covered by spouse's insurance? ❑ yes ❑ no

Spouse's dental insurance company _____ Group number _____

Spouse's birthday _____ Social Security number _____

MEDICAL INFORMATION

Are you currently under the care of a physician? ❑ Yes ❑ No Your current physical health is: ❑ Good ❑ Fair ❑Poor

Physician's Name: _____ Phone Number: (____)_____

Date of last visit/Physical Exam: _____/_____/_____

Has there been any change in your general health within the past year? ❑ Yes ❑ No

If yes, what condition is being treated?

Are you taking any prescription/over-the-counter or herbal supplement medications: ❑ Yes ❑ No

Please list all medications including OTC and Herbal Supplements (Please turn over if more room is needed):

_____

_____

_____

_____

PLEASE MARK (X) your response to indicate if you have or have not had any of the following diseases or problems

- ❑ Cancer or tumor
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Pacemaker
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
  Date of Joint Replacement: _____
- ❑ High or low blood pressure
- ❑ Tuberculosis or other lung problems (COPD)
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcohol / Drug Abuse
- ❑ Blood transfusion
- ❑ Diabetes…… Type I or Type II
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Depression/Anxiety
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Food:
- ❑ Animals:
- ❑ Hayfever/Seasonal
- ❑ Other:_____

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine

Women:

- ❑ May be pregnant
  Expected delivery date: _____
- ❑ Taking hormones or contraceptives
- ❑ Nursing

Do you have any disease, condition, or problem not listed above?_____

_____

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set foth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. I certify that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. Our office is HIPPA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

Signature of patient:_____ Date: _____

DENTAL INFORMATION AND DENTAL HISTORY

Your current dental health is: ❑ Good ❑ Fair ❑Poor

Are you currently experiencing any dental pain or discomfort? ❑ yes ❑ no
Do your gums bleed when you brush or floss? ❑ yes ❑ no
Are your teeth sensitive to cold,hot,sweets,chewing? ❑ yes ❑ no
Does food or floss catch between your teeth? ❑ yes ❑ no
Is your mouth dry? ❑ yes ❑ no
Have you had any periodontal (gum) treatment? ❑ yes ❑ no
Have you ever had orthodontic (braces) treatment? ❑ yes ❑ no
Have you had any problems associated with previous dental treatment? ❑ yes ❑ no
Is your home water supply fluoridated? ❑ yes ❑ no
Do you have any clicking,popping, or discomfort in the jaw? ❑ yes ❑ no
Do you brux, grind, or clench your teeth? ❑ yes ❑ no
Do you wear dentures or partials? ❑ yes ❑ no

What Type of Toothpaste you use?
Do you use an electric Toothbrush? ❑ yes ❑ no
How many times a day do you brush your teeth?
Do you Floss? ❑ yes ❑ no How many Times Per Week? _____

If I could change my smile I would make my teeth:

Whiter ❑ Replace old crowns or caps ❑
Straighter ❑ Less gum showing ❑
Close spaces: ❑
Replace stained front fillings: ❑
Repair chipped teeth: ❑

Have you experienced any of the following problems:

Snoring ❑
Sleep Apnea ❑
Bad Breath ❑
Tooth Grinding/Clenching ❑
Teeth ache in the morning ❑
Soreness in jaw joint? ❑

Do You Drink Coffee or Tea? ❑ yes ❑ no

❑ Black ❑ Milk ❑ Flavored Creamers ❑ Sugar

What is your main choice of beverage? ❑ Water ❑ Soda/Pop ❑ Energy Drinks ❑ Iced Tea ❑Other

Please list any other dental concerns that you may have:

DATE OF YOUR LAST DENTAL CLEANING: **DATE OF LAST DENTAL X-RAYS:**

We look forward to helping you maintain excellent oral health!