Dalin Dental Associates

Name_____ (First) (Middle) (Last) | ❑ M ❑ F Sex | ❑S ❑M ❑W ❑D Marital Status

Address_____ (Street) (City) (Zip Code)

Home Phone (____) ____-____ Cell Phone (____) ____-____ Email_____

Employed by_____ Occupation_____

Work Phone (____) ____-____ ext.____ Date of Birth_____

Patient SS#_____ Spouse Name_____

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE
Policy Holder_____	Policy Holder_____
Date of Birth_____	Date of Birth_____
Relationship to Patient_____	Relationship to Patient_____
Employer_____	Employer_____
Group #_____	Group #_____
SS#_____ ID#_____	SS#_____ ID#_____
Name of Insurance Co._____	Name of Insurance Co._____
Claims Address_____	Claims Address_____
_____	_____
Phone #_(_____)_____-_____	Phone #_(_____)_____-_____

Hobbies and Interests_____

Referred to our office by_____

Emergency Contact_____ Phone # (____) ____-____

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical and dental histories are correct to the best of my knowledge.

_____ (Signature of Dentist)

_____ (Signature of Patient)

Patient Name

DENTAL HISTORY

Welcome! *So that we may provide you with the best possible care* ***PLEASE COMPLETE BOTH SIDES*** *of this medical/dental history form. All information is completely confidential.*

What is the reason for your visit today?_____

_____

Date of Last Dental Visit:___/___/___ **Last Dental Cleaning:**___/___/___ **Last Full Mouth X-rays:**___/___/___

What was done at your last dental visit?_____

_____

Previous Dentist's Name_____

Address_____ State_____ Zip_____

Telephone_____

How often do you have dental examinations?_____

How often do you brush your teeth?_____ How often do you floss?_____

What other dental aids do you use? (Interplak, toothpick, etc.)_____

Do you have any dental problems now? ❑ yes ❑ no

If yes, please describe:_____

_____

Are any of your teeth sensitive to:

Hot or cold? ❑ yes ❑ no

Sweets? ❑ yes ❑ no

Biting or chewing? ❑ yes ❑ no

Have you noticed any mouth odors or bad taste? ❑ yes ❑ no

Do you frequently get cold sores, blisters or any other oral lesions? ❑ yes ❑ no

Do your gums bleed or hurt? ❑ yes ❑ no

Have your parents experienced gum disease or tooth loss? ❑ yes ❑ no

Have you noticed any loose teeth or change in your bite? ❑ yes ❑ no

Does food tend to become caught in between your teeth? ❑ yes ❑ no

If yes, where?_____

Do you:

Clench or grind your teeth while awake or asleep? ❑ yes ❑ no

Bite your lips, fingernails or cheeks regularly? ❑ yes ❑ no

Hold foreign objects with your teeth? (pencils, pipe, pins, nails) ❑ yes ❑ no

Mouth breathing while awake or asleep? ❑ yes ❑ no

Have tired jaws, especially in the morning? ❑ yes ❑ no

Smoke/chew tobacco? ❑ yes ❑ no

Have you ever had:

Orthodontic treatment? ❑ yes ❑ no

Oral surgery? ❑ yes ❑ no

Periodontal treatment? ❑ yes ❑ no

Your teeth ground or the bite adjusted? ❑ yes ❑ no

A bite plate or mouth guard? ❑ yes ❑ no

A serious injury to the mouth or head? ❑ yes ❑ no

If yes, please describe, including cause_____

_____

Have you experienced:

Clicking or popping of the jaw? ❑ yes ❑ no

Pain? (joint, ear, side of face) ❑ yes ❑ no

Difficulty in opening or closing the mouth? ❑ yes ❑ no

Difficulty in chewing on either side of the mouth? ❑ yes ❑ no

Headaches, neckaches or shoulder aches? ❑ yes ❑ no

Sore muscles (neck, shoulders)? ❑ yes ❑ no

Are you satisfied with your teeth's appearance? ❑ yes ❑ no

Do you feel nervous about having dental treatment? ❑ yes ❑ no

If so, what is your biggest concern?_____

_____

Have you ever had an upsetting dental experience? ❑ yes ❑ no

If yes, please describe_____

_____

Is there anything else about having dental treatment that you would like us to know? ❑ yes ❑ no

If yes, please describe_____

_____

_____

_____

Patient Name

MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years? ❑ yes ❑ no
   If yes, for what_____
   Physician's Name_____Phone_____
   Address_____ City_____ State_____ Zip_____
2. Have you taken any medication or drugs during the past two years? ❑ yes ❑ no
3. Are you taking any medication, drugs or pills now? ❑ yes ❑ no
   If yes, please list name, dosage & what medication is for_____
   _____
4. Are you aware of having an allergic (or adverse) reaction to any medications or substance? ❑ yes ❑ no
   If yes, please list:_____
5. Have you been a patient in the hospital during the past five years? ❑ yes ❑ no
6. Indicate which of the following you have had, or have at present. Please check "yes" or "no" to each item.

A.I.D.S.	❑ yes	❑ no	Emphysema	❑ yes	❑ no	Neurological Disorders	❑ yes	❑ no
Allergies or Hives	❑ yes	❑ no	Epilepsy or Seizures	❑ yes	❑ no	Premedication	❑ yes	❑ no
Arthritis/Rheumatism	❑ yes	❑ no	Fainting or Dizzy Spells	❑ yes	❑ no	Psychiatric/Psychological Care	❑ yes	❑ no
Artificial Heart Valve	❑ yes	❑ no	Glaucoma	❑ yes	❑ no	Radiation Therapy	❑ yes	❑ no
Artificial Joints(hip, knee, etc.)	❑ yes	❑ no	H.I.V. Positive	❑ yes	❑ no	Rheumatic Fever	❑ yes	❑ no
Asthma	❑ yes	❑ no	Hay Fever	❑ yes	❑ no	Sickle Cell Disease	❑ yes	❑ no
Blood Transfusion	❑ yes	❑ no	Heart (Surgery, Disease, Attack)	❑ yes	❑ no	Sinus Trouble	❑ yes	❑ no
Bruise Easily	❑ yes	❑ no	Heart Murmur	❑ yes	❑ no	Stroke	❑ yes	❑ no
Chemotherapy	❑ yes	❑ no	Heart Pacemaker	❑ yes	❑ no	Swollen Ankles	❑ yes	❑ no
Chest Pain	❑ yes	❑ no	Hemophilia	❑ yes	❑ no	Thyroid Problems	❑ yes	❑ no
Chronic Cough	❑ yes	❑ no	Hepatitis A (infectious) B (serum)	❑ yes	❑ no	Tuberculosis	❑ yes	❑ no
Cold Sores/Fever Blisters	❑ yes	❑ no	High Blood Pressure	❑ yes	❑ no	Tumors	❑ yes	❑ no
Congenital Heart Disease	❑ yes	❑ no	Kidney Trouble	❑ yes	❑ no	Ulcers	❑ yes	❑ no
Contact Lenses	❑ yes	❑ no	Latex Sensitivity	❑ yes	❑ no	Venereal Disease	❑ yes	❑ no
Cortisone Medication	❑ yes	❑ no	Liver Disease	❑ yes	❑ no	Yellow Jaundice	❑ yes	❑ no
Diabetes	❑ yes	❑ no	Mital Valve Prolapse	❑ yes	❑ no			
Diet(Special/Restricted)	❑ yes	❑ no	Nervous/Anxious	❑ yes	❑ no			

7. Are you taking or have you ever taken biophosphonates (Actonel , Fosamax, Boniva)? ❑ yes ❑ no
8. Do you have or have you had disease, condition, or problem not listed? ❑ yes ❑ no
   If yes, please list:_____
   _____
9. **Women:** Are you: **Pregnant?** ❑ yes, months___ ❑ no **Nursing?** ❑ yes ❑ no **Taking birth control pills?** ❑ yes ❑ no

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

Patient Signature _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, (print name)_____, have been made aware of this office's Notice of Privacy Practices.

_____ Signature

_____ Date