Date_______________

Patient Name___________________________
SSN # ___________________________
E-mail___________________________
Address___________________________
City___________________________
State_______________ Zip_______________
Sex ☐ M ☐ F Age________ Birthdate_______________
☐ Married ☐ Widowed ☐ Single
☐ Separated ☐ Divorced ☐ Minor

Occupation___________________________
Patient Employer/School___________________________
Employer/School Phone (________)___________________
Spouse's Name___________________________
Spouse's Phone (________)___________________
Spouse's Birthdate_______________ SS/ID#_______________
Whom May We Thank For Referring You?
____

DENTAL INSURANCE

Subscriber's Name___________________________
Employer___________________________
Relationship to Patient___________________________
Birthdate_______________ SS/ID #_______________
Insurance Co___________________________
Group #_______________ Phone (________)_______________

Is Patient Covered by Secondary Coverage? ☐ Y ☐ N
Subscriber's Name___________________________
Relationship to Patient___________________________
Birthdate_______________ SS/ID#_______________
Insurance Co___________________________
Group #_______________ Phone (________)_______________

PHONE NUMBERS

Home (________)_______________ Work (________)_______________EXT____ Cell (________)_______________
Spouse's Work (________)_______________ Best Time and Place to Reach You___________________________
In Case of Emergency, Contact:
Name: ___________________________ Relationship ___________________________
Home (________)_______________ Work (________)_______________EXT____ Cell (________)_______________

DENTAL HISTORY

Reason for today's visit_______________
____
Former Dentist_______________
City/State _______________
Date of Last Dental Visit_______________
Date of Last Dental X-Rays_______________
How often do you floss?_______________
How often do you brush?_______________
Do you wear contacts? ☐ Yes ☐ No

Please circle "yes" or "no" to indicate if you had any of the following:

Bad Breath	Yes /No	Lip or Cheek Biting	Yes /No
Bleeding Gums	Yes /No	Loose Teeth/Broken Fillings	Yes /No
Blisters on Lips/Mouth	Yes /No	Mouth Breathing	Yes /No
Burning Sensation on Tongue	Yes /No	Mouth Pain	Yes /No
Chew on One Side of Mouth	Yes /No	Orthodontic Treatment	Yes /No
Clicking or Popping Jaws	Yes /No	Pain around Ear	Yes /No
Dry Mouth	Yes /No	Periodontal Treatment	Yes /No
Fingernail Biting	Yes /No	Sensitivity to Cold	Yes /No
Food Traps between Teeth	Yes /No	Sensitivity to Heat	Yes /No
Foreign Objects in Mouth	Yes /No	Sensitivity to Sweets	Yes /No
Grinding Teeth	Yes /No	Sensitivity when Biting	Yes /No
Gums Swollen or Tender	Yes /No	Sores or Growths in Mouth	Yes /No
Jaw Pain or Tiredness	Yes /No	Tobacco Use	Yes /No

MEDICAL HISTORY

Physician's Name ______________________________ Date of Last Visit ______________

Phone (______) __________ Pharmacy ______________________________ Phone (______) __________

Please circle yes or no to indicate if you have had any of the following:

AIDS	Yes / No
Anemia	Yes / No
Arthritis, Rheumatism	Yes / No
Asthma	Yes / No
Back Problems	Yes / No
Cancer	Yes / No
Chemical Dependency	Yes / No
Chemotherapy	Yes / No
Circulatory Problems	Yes / No
Cortisone Treatments	Yes / No
Cough, persistent or bloody	Yes / No
Diabetes	Yes / No
Emphysema	Yes / No
Epilepsy	Yes / No
Fainting or Dizziness	Yes / No
Glaucoma	Yes / No
Headaches	Yes / No
Heart Problems	Yes / No
Hepatitis Type _____	Yes / No
Herpes	Yes / No

Have you ever had any complications following dental treatment? Yes / No

If yes, please describe ________________

____

Have you ever been hospitalized or had any other health concerns? Yes / No

If yes, please describe ________________

____

Women: Are you pregnant? Yes /No

Due Date: ____________________

Are you nursing? Yes /No

Taking birth control pills? Yes /No

High Blood Pressure	Yes / No
HIV Positive	Yes / No
Jaundice	Yes / No
Jaw Pain	Yes / No
Kidney Disease	Yes / No
Liver Disease	Yes / No
Low Blood Pressure	Yes / No
Nervous Problems	Yes / No
Psychiatric Care	Yes / No
Radiation treatment	Yes / No
Respiratory Disease	Yes / No
Scarlet Fever	Yes / No
Shortness of Breath	Yes / No
Sinus Trouble	Yes / No
Skin Rash	Yes / No
Special Diet/Weight Loss	Yes / No
Stroke	Yes / No
Swollen Feet or Ankles	Yes / No
Swollen Neck Glands	Yes / No
Thyroid Problems	Yes / No

Have you ever taken any of these medications?

Blood thinners	Yes / No
Coumadin	Yes / No
Warfarin	Yes / No
Plavix	Yes / No
Diet Medications	Yes / No
Fen-Phen	Yes / No
Pondimen	Yes / No
Redux	Yes / No
Levoxyl	Yes / No
Synthroid	Yes / No

Tonsillitis	Yes / No
Tuberculosis	Yes / No
Tumors or Growths	Yes / No
Ulcer	Yes / No
Venereal Disease	Yes / No

Have you ever had or been diagnosed with:

Artificial Heart Valves	Yes / No
Artificial Joints, Screws, Pins, etc.	Yes / No
Bleeding abnormally, with extractions or surgery	Yes / No
Blood disease	Yes / No
Congenital Heart Lesions	Yes / No
Heart Murmur	Yes / No
Hernia Repair	Yes / No
Mitral Valve Prolapse	Yes / No
Pacemaker	Yes / No
Rheumatic Fever	Yes / No

Are you allergic to?

Aspirin	Yes / No
Barbiturates	Yes / No
Codeine	Yes / No
Ibuprofen	Yes / No
Latex	Yes / No
Local Anesthesia	Yes / No
Metals (i.e. gold)	Yes / No
Penicillin	Yes / No
Sulfa	Yes / No

Other:____________________________

____

Please list print all medications now taking:______________________________

____

Assignment & release: I authorize my insurance company to pay Dr. Karla Boyd directly, for all services rendered. If services are not paid by my insurance I understand that I am financially responsible. I authorize the use of my signature on all insurance submissions. Dr. Karla Boyd may disclose my healthcare information to my insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature______________________ **Print Name**______________________ **Date**__________

Patient's Name (if unable to sign)__________________ **Relationship to Patient**__________________