

STOW DENTAL CARE

To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information

Name _____ Date _____
 Address _____ City _____ State _____ Zip _____
 Home Phone _____ Cell Phone _____
 E-Mail _____ SS # _____ Birthdate _____
 Check Appropriate Box: Minor Single Married Separated Divorced Widowed
 If Student, Name of School/College _____ City _____ State _____
 Patient's or Parent/Guardian's Employer _____ Work Phone _____
 Business Address _____ City _____ State _____ Zip _____
 Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____
 Whom May We Thank for Referring You? _____
 Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____
 Address _____ Home Phone _____
 E-Mail _____ Cell Phone _____
 Driver's License # _____ Birthdate _____
 Employer _____ Work Phone _____ SS # _____

Is this Person Currently a Patient in our Office? Yes No

For your convenience, we offer the following methods of payment. Please Payment is due in full at each appointment.

Cash – CareCredit – All Major Credit Cards

Patient Dental History

Name of Previous Dentist and Location _____ Date of last dental exam? _____

	Yes	No		Yes	No
1. Do your gums bleed while brushing or flossing?	<input type="checkbox"/>	<input type="checkbox"/>	10. Have you ever had any difficult extractions in the		
2. Are your teeth sensitive to hot or cold liquids/foods?	<input type="checkbox"/>	<input type="checkbox"/>	past?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are your teeth sensitive to sweet or sour liquids/foods?	<input type="checkbox"/>	<input type="checkbox"/>	11. Have you ever had any prolonged bleeding		
4. Do you feel pain to any of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	following extractions?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any sores or lumps in or near your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	12. Have you had any orthodontic treatment?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you had any head, neck or jaw injuries?	<input type="checkbox"/>	<input type="checkbox"/>	13. Do you wear dentures or partials?	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, date of placement _____		
8. Have you ever experienced any of the following			14. Have you ever received oral hygiene instructions		
problems in your jaw?			regarding the care of your teeth and gums?	<input type="checkbox"/>	<input type="checkbox"/>
Clicking	<input type="checkbox"/>	<input type="checkbox"/>	15. Do you like your smile?	<input type="checkbox"/>	<input type="checkbox"/>
Pain (joint, ear, side of face)	<input type="checkbox"/>	<input type="checkbox"/>	16. Do you have dry Mouth?	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in opening or closing	<input type="checkbox"/>	<input type="checkbox"/>			
Difficulty in chewing	<input type="checkbox"/>	<input type="checkbox"/>			
Do you clench or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>			
Do you bite your lips or cheeks frequently?	<input type="checkbox"/>	<input type="checkbox"/>			
9. Are you in pain now?	<input type="checkbox"/>	<input type="checkbox"/>			

Patient Health History

1. Is your general health good? _____
 2. Has there been a change in your health within the last year? _____
 3. Have you been hospitalized or had a serious illness in the last three years? _____
 4. Are you being treated by a physician now? For What? _____
 Date of last medical exam? _____
 5. Have you had problems with prior dental treatment? _____

Have you experienced	Yes	No		Yes	No
Chest pain (angina)?	<input type="checkbox"/>	<input type="checkbox"/>	Headaches?	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells and/or vertigo?	<input type="checkbox"/>	<input type="checkbox"/>
Recent weight loss?	<input type="checkbox"/>	<input type="checkbox"/>	Blurred vision?	<input type="checkbox"/>	<input type="checkbox"/>
Persistent cough, coughing up blood?	<input type="checkbox"/>	<input type="checkbox"/>	Seizures?	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding problems, bruising easily?	<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst?	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems?	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal problems?	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty swallowing?	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice?	<input type="checkbox"/>	<input type="checkbox"/>
Aphthous ulcers/canker sores?	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness?	<input type="checkbox"/>	<input type="checkbox"/>

Do you have:	Yes	No		Yes	No
Heart disease/heart defects?	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis, other liver disease?	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart problems?	<input type="checkbox"/>	<input type="checkbox"/>	Stomach problems, ulcers?	<input type="checkbox"/>	<input type="checkbox"/>
Mitral valve prolapses?	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted disease?	<input type="checkbox"/>	<input type="checkbox"/>
Prosthetic heart valve?	<input type="checkbox"/>	<input type="checkbox"/>	AIDS/HIV infection?	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever?	<input type="checkbox"/>	<input type="checkbox"/>	Herpes/cold sores?	<input type="checkbox"/>	<input type="checkbox"/>
Stroke, hardening of arteries?	<input type="checkbox"/>	<input type="checkbox"/>	Tumors, cancer?	<input type="checkbox"/>	<input type="checkbox"/>
Artificial joint/metal?	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis, rheumatism?	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	Eye diseases?	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	Skin diseases?	<input type="checkbox"/>	<input type="checkbox"/>
Hypoglycemia?	<input type="checkbox"/>	<input type="checkbox"/>	Anemia?	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	Kidney, bladder disease?	<input type="checkbox"/>	<input type="checkbox"/>
Asthma?	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid, adrenal disease?	<input type="checkbox"/>	<input type="checkbox"/>
TB, emphysema, other lung diseases or persistent cough?	<input type="checkbox"/>	<input type="checkbox"/>	Eating disorders?	<input type="checkbox"/>	<input type="checkbox"/>

Do you have or have you ever had :	Yes	No		Yes	No
Psychiatric care?	<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusions?	<input type="checkbox"/>	<input type="checkbox"/>
Radiation treatments?	<input type="checkbox"/>	<input type="checkbox"/>	Surgeries?	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy?	<input type="checkbox"/>	<input type="checkbox"/>	Contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever taken Fosamax, Boniva, Actonel or any medication containing bisphosphonates?	<input type="checkbox"/>	<input type="checkbox"/>
Hospitalization?	<input type="checkbox"/>	<input type="checkbox"/>			

Are you allergic any of the following:	Yes	No	Are you taking:	Yes	No
Local Anesthetics (e.g. Novocaine)?	<input type="checkbox"/>	<input type="checkbox"/>	Recreational drugs?	<input type="checkbox"/>	<input type="checkbox"/>
Antibiotics?	<input type="checkbox"/>	<input type="checkbox"/>	Controlled substances?	<input type="checkbox"/>	<input type="checkbox"/>
If so, which ones? _____			Drugs, medications, over-the-counter medicines (including Aspirin), natural remedies?	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa Drugs?	<input type="checkbox"/>	<input type="checkbox"/>	Blood thinners (such as Coumadin or Warfarin)?	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates?	<input type="checkbox"/>	<input type="checkbox"/>	Medications for opiate dependency?	<input type="checkbox"/>	<input type="checkbox"/>
Sedatives?	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco in any form?	<input type="checkbox"/>	<input type="checkbox"/>
Iodine?	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin?	<input type="checkbox"/>	<input type="checkbox"/>	PLEASE LIST ALL MEDICATIONS _____		
Any Metals (e.g. nickel, mercury, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Latex Rubber?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Other? _____			_____		

Women only:	Yes	No	All patients:	Yes	No
Are you or could you be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have or have you had any other diseases or medical problems NOT listed on this form? (Example, ADHD, Depression, Learning Disabilities) If so, please explain:	<input type="checkbox"/>	<input type="checkbox"/>
Taking birth control pills?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Breast-feeding?	<input type="checkbox"/>	<input type="checkbox"/>	_____		

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____ Date _____

Hygienist or Doctor Comments :	

Doctor Signature _____	Date _____
Hygienist Signature _____	Date _____