Sprucewood Dental Associates, PC.

General Dentistry

Patient Information

TODAY'S DATE _____

FULL NAME _____ DATE OF BIRTH _____ RESPONSIBLE PARTY _____

STREET ADDRESS _____ SOCIAL SECURITY NUMBER _____

CITY, STATE, ZIP _____ HOME PHONE _____ WORK NUMBER _____ CELL PHONE _____ E-MAIL _____

OCCUPATION/EMPLOYER _____ PLEASE CIRCLE YOUR PREFERENCE OF CONTACT FOR YOUR APPOINMENT CONFIRMATION

SPOUSE/NEAREST RELATIVE _____ STUDENT'S NAME OF SCHOOL _____

CHILDREN _____

HOBBIES/INTERESTS _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR CARE? _____

Dental Insurance Information

INSURANCE COMPANY _____ INSURANCE COMPANY _____

EMPLOYEE NAME _____ D.O.B. _____ EMPLOYEE NAME _____ D.O.B. _____

GROUP NUMBER _____ GROUP NUMBER _____

EMPLOYER _____ EMPLOYER _____

ID NUMBER _____ ID NUMBER _____

Medical Information

Date of last routine physical? _____

Blood pressure reading _____ Date Taken _____

Physician's name and phone number _____

Are you being treated for a specific medical condition? _____

please explain _____

Any other medical concerns? _____

Please list all current medications, supplements, vitimins, & herbal remedies _____

Please list all additional medications that you have taken in the last **two** (2) **years** including supplements, vitamins & herbal remedies _____

_____

MEDICAL HISTORY

PATIENT NAME _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No ◯ N/A _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No ◯ N/A _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No ◯ N/A _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No ◯ N/A _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications using bisphosphonates? ◯ Yes ◯ No ◯ N/A _____

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you ☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you aware of being allergic to or have ever reacted adversely to any medication or substance?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Sulfa Drugs ☐ Other _____

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

☐ AIDS/HIV Positive	☐ Cold Sores/Fever Blisters	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Alzheimer's Disease	☐ Congenital Heart Disorder	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Anaphylaxis	☐ Convulsions	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifada
☐ Anemia	☐ Cortisone Medicine	☐ Heart Murmur*	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Angina	☐ Diabetes	☐ Heart Pace Maker*	☐ Mitral Valve Prolapse*	☐ Stroke
☐ Arthritis/Gout	☐ Drug Addiction	☐ Heart Trouble/Disease	☐ Osteoporosis	☐ Swelling of Limbs
☐ Artificial Heart Valve*	☐ Easily Winded	☐ Hemophilia	☐ Pain in Jaw Joints	☐ Thyroid Disease
☐ Artificial Joint*	☐ Emphysema	☐ Hepatitis A	☐ Parathyroid Disease	☐ Tonsillitis
☐ Asthma	☐ Epilepsy or Seizures	☐ Hepatitis B or C	☐ Psychiatric Care	☐ Tuberculosis
☐ Blood Disease	☐ Excessive Bleeding	☐ Herpes	☐ Radiation Treatments	☐ Tumors or Growths
☐ Blood Transfusion	☐ Excessive Thirst	☐ High Blood Pressure	☐ Recent Weight Loss	☐ Ulcers
☐ Breathing Problem	☐ Fainting Spells/Dizziness	☐ High Cholesterol	☐ Renal Dialysis	☐ Venereal Disease
☐ Bruise Easily	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever*	☐ Yellow Jaundice
☐ Cancer	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	
☐ Chemotherapy	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever	
☐ Chest Pains	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles	

Have you ever had any serious illness not listed above? ◯ Yes ◯ No ◯ N/A _____

Comments: _____

_____

_____

* Condition may require medication

Please contact physician prior to your initial visit.

I understand the above information is necessary to provide me with dental care in a safe and efficient manner.
I have answered all the questions truthfully and to the best of my knowledge.
I give my permission for the dental team to consult with my physician on questions pertaining to the above information.

I understand that I am responsible for ALL fees regardless of insurance coverage. I also understand that as treatment progresses that fees may have to be adjusted. If I do not pay the entire balance within 30 days of the monthly billing date, a late charge of 1.83% on the balance then unpaid and owed will be assessed each month. I agree to pay all costs of collections, including but not limited to, reasonable attorney's fees.

_____ _____

PATIENT SIGNATURE DATE