SEA COUNTRY DENTAL

File #: ____________________

1. ABOUT YOU

Today's Date:_________/___________/________

Patient Name: ____
Last First MI

What do you prefer to be called:_______________

Birthdate:______/______/____ Age today: ______ ❏ Male ❏ Female

SS #: ____

Mailing Address: ____

CITY__________________________ ST_______ ZIP_______________

Cell Phone #: (___)____

Work Phone #: (___)_______________________________ Ext: ______

Home Phone #:(___)____

E-mail Address:____

Referred By:____

Patient's Employer:_____________________ How Long?_______

Employer's Address:_______________________________________

CITY _____________________ ST_______________ Zip_________

Occupation:____

Status: ❏ Minor ❏ Single ❏ Married ❏ Divorced ❏ Seperated ❏ Widowed

Spouse's Name:____

Do you have children? ❏ Yes ❏ No How many?________________

2. INSURANCE INFO

Primary Dental Insurance

Insurance Co.:__________________________________

Address: ______________________________________

CITY_____________________ ST______ ZIP_________

Phone #: ______________________________________

Insured's Name: _________________________________

Insured's SS#:__________________________________

Group # (Plan, Local, or Policy #):______________________

Relation:___________Date of Birth:______/______/_______

Insured's Employer:______________________________

Secondary Dental Insurance

Insurance Co.:__________________________________

Address:_______________________________________

CITY_____________________ST______ ZIP__________

Phone #:_______________________________________

Insured's Name:_________________________________

Insured's SS#:__________________________________

Group #:______________________________________

Relation:___________Date of Birth:______/______/_______

Insured's Employer:______________________________

3. IN EVENT OF EMERGENCY

Whom should we contact?____________________________________Relation:______________________________

Home Phone #: ____________________________________ Work Phone #:________________________________

Name of Medical Doctor?_____________________________ M.D.'s Phone #:______________________________

4. DENTAL INFO

Reason for today's visit: ❏ Exam ❏ Emergency ❏ Consultation

Are you in pain: Yes No How Long? ______________________

Do you require pre-medication? Yes No Don't know

Please check ❏ any of the following problems:

❏ Discomfort, clicking or popping in jaw.
❏ Red, swollen or bleeding gums.
❏ Sensitive tooth, teeth or gums.
❏ Blisters/Sores in or around the mouth.
❏ Lost/Broken Filling(s)
❏ Teeth grinding
❏ Ringing in Ears
❏ Broken/Chipped tooth
❏ Stained teeth
❏ Locking Jaw
❏ Bad breath

❏ Other:____

Previous Dentist: ____ (__________) ______________________
Name Phone#

Last Dental Exam: ________/________/________ Last Dental X-rays: ________/________/________

Times a day you brush?__________ Times a week you floss?__________

What type of tooth brush bristles do you use? ❏ Soft ❏ Medium ❏ Hard

How would you rate your smile? 1 2 3 4 5 6 7 8 9 10

5. MEDICAL HISTORY

Question	Answer
Have you taken any medication or drugs during the past two years?	Yes No
Are you taking any medication, drugs or pills now?	Yes No
If yes, please list name and dosage ____________________	
Are you aware of having an allergic **(or adverse)** reaction to any medication or substance?	Yes No
If yes, please list: ____________________	
Have you been a patient in the hospital during the past five years?	Yes No

Are you taking or have you taken any of the following in the last **three months**?

Item	Answer	Item	Answer	Item	Answer
Recreational drugs	Yes No	Tobacco in any form	Yes No	Antibiotics	Yes No
Over-the-counter medicines	Yes No	Alcohol	Yes No	Supplements	Yes No
Weight loss medications	Yes No	**Bisphosphonate (Fosamax)**	**Yes No**	Asprin	Yes No

Indicate which of the following you have had, or have at present. **(Circle "yes" or "no" to each item.)**

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

Question	Answer
Do you have trouble sleeping laying flat?	Yes No
Have you lost or gained more than 10 pounds in the past year?	Yes No
Do you have or have you had any disease, condition, or problem not listed above?	Yes No

If yes, please list: ____________________

WOMEN: Are you: **Pregnant**? Yes, ____Months No **Nursing**? Yes No **Taking birth control pills**? Yes No

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

X ____________________ / ________
Signature of patient (parent or guardian) **Date**

X ____________________ / ________
Signature of dentist **Date**

MEDICAL UPDATES
I have reviewed my health history and confirm that it accurately states past and present conditions.

Date	Patient signature:	Changes to health history:	Dentist's initials