Alpine Dentistry

PATIENT INFORMATION

Welcome to Alpine Dentistry! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Patient's name _____ Preferred name _____ Birth date_____

Preferred phone _____ Email Address _____

Mailing address _____ City _____State _____ Zip _____

Employer _____ Occupation _____

Spouse's name _____ Spouse's employer _____ ❑ Unmarried

Whom may we thank for referring you to our office? _____

Emergency Contact & phone number: _____

BILLING, CREDIT, AND INSURANCE INFORMATION: ❑ Not covered by dental insurance

Your Social Security number: _____ Dental Insurance Co._____ Group number_____

Covered by spouse's insurance? ❑ yes ❑ no

Spouse's dental insurance company _____ Group number _____

Spouse's birthday _____ Social Security number _____

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Cancer or tumor
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Artificial joint or heart valve.
  Year placed: _____
- ❑ High or low blood pressure (circle one)
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease TYPE: _____
- ❑ Alcoholism
- ❑ Diabetes
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma

Do you smoke or use chewing tobacco? ❑ yes ❑ no

How often:_____

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:_____

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Other:_____

Women:

- ❑ May be pregnant
  Expected delivery date: _____

Name of your physician:_____

Do you have any disease, condition, or problem not listed above?_____

_____

Please add anything else you would like us to know about:_____

_____

DENTAL HEATH

WHAT IS THE REASON FOR YOUR VISIT TODAY? _____

_____

Date (estimate) of last dental visit _____
Date (estimate) of last dental x-rays _____
How often do you floss? _____
How often do you brush? _____

Please check if you have any of the following:

- ❑ Bad Breath
- ❑ Bleeding Gums
- ❑ Blisters on lips or mouth
- ❑ Burning sensation on tongue
- ❑ Difficulty Chewing
- ❑ Clicking or popping jaw
- ❑ Dry mouth
- ❑ Food collection between the teeth
- ❑ Grinding or clenching teeth
- ❑ Gums swollen or tender
- ❑ Loose teeth
- ❑ Broken teeth or fillings
- ❑ Mouth pain
- ❑ Current orthodontic treatment
- ❑ Sensitivity to cold, heat, or sweets
- ❑ Sensitivity when biting
- ❑ Sores or growths in mouth

Thank you! We look forward to serving you.

Signature of patient (or parent) _____