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phone **480-988-7200** fax **480-988-7318**
www.MySomersetFamilyDental.com

PATIENT INFORMATION

PATIENT NAME: _____ PREFERRED NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

MALE / FEMALE _____ **SINGLE / MARRIED** _____

SEX: _____ AGE: _____ DOB: _____ SOCIAL SECURITY #: _____ RELATIONSHIP STATUS: _____

EMAIL: _____

EMPLOYER: _____ OCCUPATION: _____

WHO MAY WE THANK FOR REFERRING YOU? _____

IN CASE OF EMERGENCY WHO SHOULD BE NOTIFIED? _____ PHONE: _____

PRIMARY INSURANCE

PERSON RESPONSIBLE FOR ACCOUNT: _____

RELATION TO PATIENT: _____ BIRTH DATE: _____ SUBSCRIBER ID#: _____ GROUP#: _____

PERSON RESPONSIBLE EMPLOYED BY: _____

INSURANCE COMPANY: _____

ADDITIONAL INSURANCE

SUBSCRIBER NAME: _____

RELATION TO PATIENT: _____ BIRTH DATE: _____ SUBSCRIBER ID#: _____ GROUP#: _____

INSURANCE COMPANY: _____

AUTHORIZATION AND RELEASE

I authorize my insurance company to pay Somerset Family Dental all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. Somerset Family Dental may use my health care information and may disclose such information to my insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services, as pertaining to the HIPPA guidelines.

_____ SIGN PATIENT NAME: _____ PRINT PATIENT NAME: _____ DATE: _____

DENTAL HISTORY

REASON FOR TODAY'S VISIT: _____

IS THERE ANYTHING YOU WOULD LIKE TO CHANGE ABOUT THE APPEARANCE OF YOUR SMILE? _____

HOW OFTEN DO YOU BRUSH? _____ HOW OFTEN DO YOU FLOSS? _____

DATE OF LAST DENTAL CLEANING: _____ DATE OF LAST DENTAL X-RAYS/EXAM: _____

MARK IF YOU HAVE HAD/HAVE PROBLEMS WITH ANY OF THE FOLLOWING:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> BAD BREATH | <input type="checkbox"/> BLEEDING GUMS | <input type="checkbox"/> JAW PAIN | <input type="checkbox"/> SENSITIVITY TO COLD/HOT |
| <input type="checkbox"/> LOOSE OR BROKEN TEETH | <input type="checkbox"/> LOOSE OR BROKEN FILLINGS | <input type="checkbox"/> PERIODONTAL TREATMENT | <input type="checkbox"/> GRINDING TEETH |
| <input type="checkbox"/> SENSITIVITY TO SWEETS | <input type="checkbox"/> SORES OR GROWTHS IN THE MOUTH | <input type="checkbox"/> SENSITIVITY WHEN BITING | <input type="checkbox"/> CLICKING OR POPPING JAW |
| <input type="checkbox"/> FOOD COLLECTION BETWEEN TEETH | | | |

MEDICAL HISTORY

PHYSICIANS NAME: _____ PHONE: _____

HAVE YOU HAD ANY SERIOUS ILLNESSES OR OPERATIONS? YES / NO

IF YES, DESCRIBE: _____

HAVE YOU HAD A BLOOD TRANSFUSION? YES / NO

IF YES, GIVE APPROXIMATE DATES: _____

HAS IT EVER BEEN NECESSARY FOR YOU TO PRE-MEDICATE FOR A DENTAL APPOINTMENT? YES / NO

IF YES, DESCRIBE: _____

ARE YOU/HAVE YOU TAKEN ANY BIPHOSPHONATE MEDICATION? YES / NO

IF YES, DESCRIBE: _____

MARK IF YOU HAVE HAD/HAVE ANY OF THE FOLLOWING:

ANEMIA	YES/NO	CIRCULATORY PROBLEMS	YES/NO	HEPATITIS	YES/NO	SCARLET FEVER	YES/NO
ARTHRITIS, RHEUMATISM	YES/NO	CORTISONE TREATMENT	YES/NO	HIGH BLOOD PRESSURE	YES/NO	SHORTNESS OF BREATH	YES/NO
ARTIFICIAL HEART VALVES	YES/NO	COUGH, PERSISTENT	YES/NO	HIV/AIDS	YES/NO	STROKE	YES/NO
ARTIFICIAL JOINTS	YES/NO	DIABETES	YES/NO	KIDNEY DISEASE	YES/NO	SWELLING OF FEET / ANKLES	YES/NO
ASTHMA	YES/NO	EPILEPSY	YES/NO	LIVER DISEASE	YES/NO	THYROID PROBLEMS	YES/NO
BACK PROBLEMS	YES/NO	FAINTING	YES/NO	MITRAL VALVE PROLAPSE	YES/NO	TOBACCO HABIT	YES/NO
BLOOD DISEASE	YES/NO	GLAUCOMA	YES/NO	PACEMAKER	YES/NO	TUBERCULOSIS	YES/NO
CANCER	YES/NO	HEART MURMUR	YES/NO	RADIATION TREATMENT	YES/NO	TONSILLITIS	YES/NO
CHEMOTHERAPY	YES/NO	HEART PROBLEMS	YES/NO	RESPIRATORY DISEASE	YES/NO	ULCERS	YES/NO
CHEMICAL DEPENDENCY	YES/NO	HEMOPHILIA	YES/NO	RHEUMATIC FEVER	YES/NO	VENEREAL DISEASE	YES/NO

WOMEN: ARE YOU PREGNANT? YES / NO ARE YOU NURSING? YES / NO TAKING BIRTH CONTROL? YES / NO

LIST MEDICATIONS YOU ARE CURRENTLY TAKING: _____

LIST ANY ALLERGIES YOU ARE AWARE OF: _____

IN OFFICE USE

HEAD & NECK EXAM WNL or _____
SOFT TISSUE WNL or _____
TMJ EXAM WNL or _____
OCCLUSION CLASS I II III
ORTHO YES NO

UPDATED MEDICAL HISTORY

_____	(DATE / INITIAL)	_____	(DATE / INITIAL)
_____	(DATE / INITIAL)	_____	(DATE / INITIAL)
_____	(DATE / INITIAL)	_____	(DATE / INITIAL)
_____	(DATE / INITIAL)	_____	(DATE / INITIAL)
_____	(DATE / INITIAL)	_____	(DATE / INITIAL)

THE ABOVE INFORMATION IS ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE WILL NOT HOLD THE DOCTOR OR ANY MEMBERS OF THEIR STAFF RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I MAY HAVE MADE IN THE COMPLETION OF THIS FORM.

SIGN PATIENT NAME:

PRINT PATIENT NAME:

DATE:

DR.'S SIGNATURE:

DATE: