Bismarck Dentistry

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We would like to get to know you better!

Date:_______________

Patient Name: ____ **SS#:** ______-_____-_______ **Male** ☐ **Female** ☐

Patient's Date of Birth _____/_____/_______ Age: _______ Marital status (circle): Single/Married/Other

Address: ____ City: ________________ State: ______ Zip:__________

Occupation:______________________________________ Employer: ____

Home Phone #: __________________________________ Work Phone #: ______________________________________

Cell Phone #: _______________________________ E-mail Address: ____

Spouse or Parent/Guardian: _________________________________ SS# Spouse/Parent: ________-_______-_________

Address (if different than above): ____ Work #: ______________________

Spouse/Parent Occupation: _____________________________ Employer: ______________________________________

Is anyone other than yourself responsible for your dental treatment? ____

Dental Insurance Information: If no insurance, please check here ☐ **Primary Insurance:** See copy of card: ☐

Name of Dental Carrier: _____________________________________ Subscriber #/Member ID ____________________

Address: ____ Subscriber Employer: ______________________

Subscriber Name: ____ Insurance Phone #: _________________________

Group #: ___________ SS Number (subscriber): _______-______-________ Subscriber D.O.B. _____/_____/________

Who may we thank for referring you? ____

Other family members that we treat? ____

When was your last dental appointment? _________________________________ Where? __________________________

Why did you leave your last dental office? ____

What is your present dental need? ____

Are you concerned about the finances required to keep your mouth in excellent dental health? YES ______ NO ______

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Are your teeth sensitive to:	**YES**	**NO**		**YES**	**NO**
Heat?	☐	☐	Pain (joints, ear, side of face)?	☐	☐
Cold?	☐	☐	Difficulty opening and closing?	☐	☐
Sweets?	☐	☐	Difficulty chewing?	☐	☐
Biting Pressure?	☐	☐	Have you had a reaction to local anesthetic?	☐	☐
Are you dissatisfied with your teeth and their appearance?	☐	☐	Do your gums bleed when brushing?	☐	☐
Have you noticed any gum swelling around any teeth?	☐	☐	Have you ever had any teeth removed?	☐	☐
Do you have an unpleasant taste or odor in your mouth?	☐	☐	How long have these been missing? ________________		
Do you feel you will eventually wear artificial dentures?	☐	☐	**Problems of the Jaw?**		
Do you have any fears?	☐	☐	Clicking of the jaw?	☐	☐

Patient Name: ____ D.O.B: _________________ Date: ____________

IN CASE OF AN EMERGENCY, PERSON TO BE CONTACTED:

Name: ____ Phone #: __________________________________

Relationship: _______________________ Address: ____

HEALTH INFORMATION:

Primary Care Physician: _______________________________ Which Clinic/Hospital?: _________________________

Y N

- ☐ ☐ Have you been hospitalized within the past 2 years? If yes, for what? ____
- ☐ ☐ Are you currently being treated by a physician? If yes, for what? ____
____
- ☐ ☐ Are you currently taking any medications or drugs? If yes, please list: ____
____
- ☐ ☐ Are there any medical issues that we should know about? ____
____
- ☐ ☐ Do you use any Tobacco products? If yes, what? ____
- ☐ ☐ Have you ever had an addiction problem with alcohol, drugs, or prescription medications? Explain: ________________
____

FEMALE Yes No	
Are you pregnant: ☐ ☐ If yes, when are you due? ___________________________ How many weeks? _______________________________	Are you nursing: ☐ Yes ☐ No Are you taking any form of birth control? ☐ Yes ☐ No If yes, I understand if given medication this may affect the Effectiveness of birth control. INITIAL __________

Y N Conditions

- ☐ ☐ High Blood Pressure
- ☐ ☐ Low Blood Pressure
- ☐ ☐ High Cholesterol
- ☐ ☐ Heart surgery
  When? __________
- ☐ ☐ Heart Attack
  When? __________
- ☐ ☐ Stroke
  When? __________
- ☐ ☐ Pace Maker
- ☐ ☐ Angina Pectoris
- ☐ ☐ Congenital Heart Defect
- ☐ ☐ Rheumatic Fever
- ☐ ☐ Mitral Valve Prolapse
- ☐ ☐ Heart Murmur
- ☐ ☐ Artificial Heart Valve
- ☐ ☐ Cancer
- ☐ ☐ Chemotherapy
  When? _________
- ☐ ☐ Radiation
  When? _________

Y N Conditions

- ☐ ☐ Asthma
- ☐ ☐ Emphysema
- ☐ ☐ Abnormal/Difficulty Breathing
- ☐ ☐ Sinus Problems
- ☐ ☐ Tuberculosis
- ☐ ☐ Osteoporosis/Osteopenia
- ☐ ☐ Bisphosphonate use
  examples: Boniva, Actonel, Zometa
- ☐ ☐ Arthritis/Rheumatoid Arthritis
- ☐ ☐ Artificial Bones/Joints
  Dates? ______________
- ☐ ☐ Diabetes: Type I or II
- ☐ ☐ Hemophilia
- ☐ ☐ Anemia
- ☐ ☐ Abnormal Bleeding
- ☐ ☐ HIV + AIDS
- ☐ ☐ Liver Disease
- ☐ ☐ Hepatitis A
- ☐ ☐ Hepatitis B
- ☐ ☐ Hepatitis C

Y N Conditions

- ☐ ☐ Acid Reflux
- ☐ ☐ Thyroid Problems
- ☐ ☐ Psychiatric Problems
- ☐ ☐ Hearing Impaired
- ☐ ☐ Fainting Spells
- ☐ ☐ Frequent Headaches
- ☐ ☐ Epilepsy
- ☐ ☐ Seizures
- ☐ ☐ Organ Transplant

Y N Allergies

- ☐ ☐ Seasonal
- ☐ ☐ Aspirin
- ☐ ☐ Codeine
- ☐ ☐ Dental Anesthetics
- ☐ ☐ Erythromycin
- ☐ ☐ Latex
- ☐ ☐ Metals
- ☐ ☐ Sulfa
- ☐ ☐ Penicillin/Amoxicillin
- ☐ ☐ Tetracycline

Other: ________________
____

I grant that any information regarding dental/medical care provided by Bismarck Dentistry may be received by the following people:

Name: Relationship

____
____

Signature of Patient or Guardian: ____ Date: _____________________________
(Must be signed)