Pomerado Dental
Patient Information

Please fill out the following confidential information Date:_____

Patient Information
Name:_____
Wish to be called:_____
Spouse(if applicable):_____
Address:_____
_____City:_____State:_____Zip:_____
Home Phone:_____Work:_____Cell:_____
Birthdate:_____ Married:_____Single:_____Child(under 18):_____
Occupation:_____
Is there another relative or family member as a patient in our office?
Their Name(s):_____

Account Information
Person Financially Responsible for Account
Name:_____
Drivers License No.:_____
Address(if different than above):_____
_____ City:_____State:_____Zip:_____

Dental Insurance Information
Primary Insurance Carrier Information
Name of Employed:_____
Place of Employment:_____ Occupation:_____
Name of Insurance Company:_____
Group Number:_____
Birthdate:_____ Social Security No._____
Secondary Insurance Carrier Information(if applicable)
Name of Employed:_____
Place of Employment:_____ Occupation:_____
Name of Insurance Company:_____
Group Number:_____
Birthdate:_____ Social Security No._____

Getting to Know You
Who can we thank for your referral to us?_____
Person to Contact for Emergency:_____
Emergency Contact Phone Number:_____
Leisure Activities or Hobbies:_____
_____

Medical History

How is your general health?_____ Date of last physical exam:_____
Physician's name:_____ Phone:_____
Are you currently being treated by a physician or psychiatrist? Y/ N
If Yes, please explain:_____
Have you been hospitalized or seriously ill within the last 10 years? Y/ N
If Yes, please explain:_____
Do you have, or have you ever had, any of the following conditions? Please circle Yes or No:

Heart Failure	**Y/ N**	**Mitral Valve Prolapse**	**Y/ N**	**Ulcers/Reflux**	**Y/ N**
Heart Attack or Disease	**Y/ N**	**Rheumatic Fever**	**Y/ N**	**Emphysema**	**Y/ N**
Angina Pectoris	**Y/ N**	**Fainting or Dizzy spells**	**Y/ N**	**Scarlet Fever**	**Y/ N**
Heart Pacemaker	**Y/ N**	**Asthma**	**Y/ N**	**A.I.D.S/H.I.V.**	**Y/ N**
High Blood Pressure	**Y/ N**	**Sinus Trouble**	**Y/ N**	**Sickle Cell Disease**	**Y/ N**
Heart Murmur	**Y/ N**	**Liver Disease**	**Y/ N**	**Bruise Easily**	**Y/ N**
Congenital Heart Lesions	**Y/N**	**Anemia**	**Y/ N**	**Thyroid Disease**	**Y/ N**
Artificial Heart Valve	**Y/ N**	**Stroke**	**Y/ N**	**Diabetes**	**Y/ N**
Heart Surgery	**Y/ N**	**Kidney Trouble**	**Y/ N**	**Chemotherapy**	**Y/ N**
Arthritis/Rheumatism	**Y/ N**	**Persistent Cough**	**Y/ N**	**Epilepsy or Seizures**	**Y/ N**
Tuberculosis(TB)	**Y/ N**	**Hepatitis(A, B, C)**	**Y/ N**	**Heart Surgery**	**Y/ N**
Artificial Joints	**Y/ N**	**Osteoporosis**	**Y/ N**	**Latex Allergy**	**Y/ N**
Hemophilia	**Y/ N**	**Cold Sores**	**Y/ N**	**Blood Transfusions**	**Y/ N**
Glaucoma	**Y/ N**	**Abnormal Bleeding**	**Y/ N**		
Allergies/Hives	**Y/ N**	**Venereal Disease**	**Y/ N**		

Have you taken Phen-Fen? Y/ N If Yes, when_____

Have you taken Fosamax? Y/ N If Yes , when_____

Do you have any disease, condition, or problem not listed that we should know about? Y/ N
If Yes, please note: _____

Are you allergic to or have you experienced an unusual reaction to any of the following drugs?
(Please circle Yes or No for each medication):

Amoxicillin	**Y/ N**	**Erythromycin**	**Y/ N**	**Other Antibiotics**	**Y/ N**
Codeine	**Y/ N**	**Penicillin**	**Y/ N**	**Valium**	**Y/ N**
Ibuprofen	**Y/ N**	**Barbiturates or Sedatives**	**Y/ N**	**Sulfa Drugs**	**Y/ N**
Aspirin	**Y/ N**	**Dental Anesthetic**	**Y/ N**	**Other**_____	

Are you taking any drugs or medications? Y/ N If Yes, please list: _____
_____

Do you use tobacco? Y/N If Yes, how much_____

Women: Are you pregnant? Y/ N If Yes, which trimester: 1st 2nd 3rd

Patient Name:_____

Patient Signature:_____ Date:_____

For Office Use Only:_____
_____

Doctor Signature and Date:_____

Dental History

Why are you visiting our office? _____

Approximate date of last visit for cleaning: _____ Treatment: _____

At what interval have your cleaning appointments been: 3-4 months 6months yearly other

Have you ever had Periodontal (Gum specialist) care? _____If yes, when_____

Do you have or are you thinking about a partial denture? _____Full denture? _____

Do you experience migraine headaches? _____

Do you suffer from pain in your face, neck or jaws? _____If yes, please explain _____
_____ Do you habitually clench or grind your teeth? _____

Have you ever had an injury to your face, neck, or jaw? _____If yes, please explain_____
_____

Are you interested in whitening your teeth? _____

Are you interested in straightening your teeth? _____

Have you ever experienced any of the following: (Please circle those that apply)

Bleeding Gums	**Sensitivity**	**Bad Breath or Bad Taste**
Swelling of Gums	**Loose Teeth**	**Food packing Between Teeth**
Pain or Soreness in Gums	**Spaces Between Teeth**	**High or Rough Fillings**
Receding Gums	**Drifting Teeth**	**Broken Teeth**

If any of the above apply please explain circumstance: _____
_____

Have you ever had a bad experience in a dental office? _____If yes, please explain_____
_____

Is there anything that concerns you about dental treatment? _____If yes, please explain_____
_____

Consent:

I, the undersigned, hereby authorizes the statements given above are true to the best of my knowledge. I also hereby authorize the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize the doctor to perform any and all forms of treatment, medication, and therapy that my be indicated in connection with (Name of Patient) _____ and further authorize and consent that the doctor chooses and employ such assistance as he deems it fit. I also understand the use of anesthetic agents embodies a certain risk. I understand responsibility for payment for Dental Services provided in this office for myself and/or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1 ½% finance charge (18% annually) will be added to any balance over 60 days. In the event of default I (we) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

In addition please note that appointments made are the patients responsibility, if a cancellation of an appointment needs to occur we require at least 24 hours notice. If at least 24 hours notice is not given a fee will be incurred.

Patient or Responsible Party_____Date_____