New Patient

BLAKE dental group

Patient Information

Let's get to know each other...

○ MRS ○ MR ○ MS ○ MISS ○ DR THIS PATIENT IS A ○ ADULT ○ CHILD

PATIENT NAME | PREFERRED NAME | SSN # (- -)

HOME ADDRESS | CITY | STATE | ZIP

HOME PHONE | OTHER PHONE | EMAIL

BIRTHDAY (/ /) | SEX | EMPLOYER / SCHOOL | OCCUPATION | REFERRED BY

Would you be available on short notice for future appointments or changes? ○ YES ○ NO

We would like to be able to send email and text communications to you, which would include appointment confirmations, newsletter, upcoming events, and important notifications. Check this box if you would like to receive these communications from us—you'll be able to unsubscribe at anytime. ○ OPT-IN

Physician and Emergency

FAMILY PHYSICIAN | PHONE

EMERGENCY CONTACT | RELATIONSHIP | PHONE

Person Responsible

Please complete the information if different from above

○ SELF ○ SPOUSE ○ PARENT ○ LEGAL GUARDIAN ○ OTHER

PERSON RESPONSIBLE FOR THIS ACCOUNT | RELATIONSHIP TO PATIENT

HOME ADDRESS | CITY | STATE | ZIP

Insurance Info

If you have a dental plan, please complete the following

SUBSCRIBER | RELATIONSHIP | DATE OF BIRTH

INSURANCE NAME | POLICY PLAN # | SUBSCRIBER ID

SUBSCRIBER (SECONDARY) | RELATIONSHIP | DATE OF BIRTH

INSURANCE NAME | POLICY PLAN # | SUBSCRIBER ID

Our Policies

Our payment, cancellation, and other policies

Unless an emergency arises, we will always try to be prompt. We appreciate all of our patients doing the same—however if you need to reschedule an appointment please give us a **48 HOURS** notice to avoid incurring a charge of **$150** for a missed appointment.

• Cash, check or credit card at the time of treatment. • If using dental insurance, we will help you with filing claims. • If payment is not made within 30 days of service, an interest charge of 1.5%/month or 18%/year on unpaid balances will incur. • After 90 days, unpaid bills will be turned over to our collection agency for which they will charge a reasonable fee, in addition to an interest of 18%/year.

I have been shown a copy of HIPAA ○ YES ○ NO

Signature _____ Date

○ PATIENT ○ PARENT ○ GUARDIAN

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Health Record
Dental & Medical

Dental History

1. Do you have a dental problem that you would like to have taken care of as soon as possible? ○ **YES** ○ **NO**

2. Have you been visiting the dentist regularly prior to visiting our practice? ○ **YES** ○ **NO**

3. Date of last dental visit: ____/____/____.
Date of last cleaning: ____/____/____.

4. When did you last have dental x-rays taken? ____/____/____

5. How often do you brush your teeth? _____

6. How often do you floss your teeth? _____

7. Do your gums bleed when you brush or floss your teeth? ○ **YES** ○ **NO**

8. Do you feel any pain in your teeth? ○ **YES** ○ **NO**

9. Do you think you have bad breath at times? ○ **YES** ○ **NO**

10. Have you ever had an injury to your mouth or jaw? ○ **YES** ○ **NO**

11. Do you have any pain in your jaw joints? ○ **YES** ○ **NO**

12. Do you suffer from migraine headaches? ○ **YES** ○ **NO**

13. Have you had your wisdom teeth extracted? ○ **YES** ○ **NO**

14. Have you ever received a dental implant? If so please provide the approximate date(s): ____/____/____

15. Do you grind or clench your teeth during the daytime or at night? ○ **YES** ○ **NO**

16. Do you smoke or use any other form of tobacco? ○ **YES** ○ **NO**

17. Have you noticed any lumps, growths, or sore spots in your mouth? ○ **YES** ○ **NO**

18 Have you ever had periodontal treatment or been referred to a periodontist? ○ **YES** ○ **NO**

19. Have you had any previous problems with dental treatment? ○ **YES** ○ **NO**

20 Are you happy with the appearance of your teeth? ○ **YES** ○ **NO**

21. Are you nervous about coming to the dentist or undergoing dental treatment? ○ **YES** ○ **NO**

22. Do you experience frequent dry mouth? ○ **YES** ○ **NO**

23. Do you snore? ○ **YES** ○ **NO**

24. Do you use a C-PAP machine? ○ **YES** ○ **NO**

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Health Record
Dental & Medical

Medical History

1. Are you in good health? ○ **YES** ○ **NO**

2. Have you had any significant changes to your health or weight in the last year? ○ **YES** ○ **NO**

3. Are you currently being treated for any medical condition or have you been in the last year? ○ **YES** ○ **NO**

4. Do you have a primary care physician? If so then who _____

5. When was your last physical examination by your primary care physician? _____

6. Have you ever been hospitalized for an illness or any other medical condition? ○ **YES** ○ **NO**

7. Please list any medications, non-prescription drugs, or herbal supplements that you currently take:

_____

8. Do you have any allergies to medication, latex/rubber, or anything else? If yes please list:

_____

9. Do you experience any difficulty walking or exercising or experience shortness of breath? ○ **YES** ○ **NO**

10. Please list and provide the date of any surgery that you have ever had: _____

11. Have you ever been instructed to take an antibiotic premedication prior to dental treatment or a dental cleaning? ○ **YES** ○ **NO**

12. Do you have any artificial joints or heart valves? ○ **YES** ○ **NO**

13. Do you have HIV, leukemia, or any other condition that could impact your immune system? ○ **YES** ○ **NO**

If HIV+ are you currently in care? ○ **YES** ○ **NO**

14. Do you experience prolonged bleeding, have a bleeding disorder, or are taking blood thinners? ○ **YES** ○ **NO**

15. Please check any of the following conditions that you have ever had or currently have:

- ○ Chest pain, angina
- ○ Heart attack
- ○ Stroke
- ○ Rheumatic fever
- ○ Mitral valve prolapse
- ○ Heart problems, murmur
- ○ Asthma or Emphysema
- ○ Pacemaker
- ○ Lung disease
- ○ Tuberculosis
- ○ Osteoporosis medication
- ○ Psychiatric disorder / treatment
- ○ Circulatory problems
- ○ Blood transfusions
- ○ Eating disorder
- ○ Fainting / Dizzy spells
- ○ Low blood pressure
- ○ Hyper / Hypoglycemia
- ○ Mental or Nervous disorder
- ○ Other communicable disease / Transmissible infection
- ○ Cancer
- ○ Steroid therapy
- ○ Diabetes
- ○ Stomach ulcers
- ○ High blood pressure
- ○ Arthritis / Rheumatism
- ○ Seizures / Epilepsy
- ○ Kidney disease
- ○ Thyroid disease
- ○ Drug / Alcohol dependency

16. Please list any other condition that you have had not listed above: _____

17. Are you currently pregnant or breastfeeding? If pregnant, expected delivery date: ____/____/____

18. Have you developed a fever or chills in the last 24 hours? ○ **YES** ○ **NO**

19. Have you noticed a new rash, lesion, or outbreak anywhere on your skin? ○ **YES** ○ **NO**

20. Are your immunizations up to date? ○ **YES** ○ **NO**

21. Have you ever taken any oral or IV bisphosphonates (i.e. Fosomax, Reclast, Zoledronic acid, etc)? ○ **YES** ○ **NO**

22. Which medications do you normally take to manage pain? (i.e. Tylenol, advil, etc): _____

23. Have you ever been treated with radiation therapy to your head, neck, or jaw? ○ **YES** ○ **NO**

24. Have you ever undergone chemotherapy? ○ **YES** ○ **NO**

25. Is there any additional information pertaining to your overall health or dental history that has not been addressed above? ○ **YES** ○ **NO**