

St. Luke's Dental

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we will be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Name _____ DOB _____ Date _____
Last First MI

Address _____ City _____ Zip _____

Soc. Sec. # _____ Home # _____ Cell # _____ Wk # _____

Email _____ Relationship to Insurance Subscriber _____

Sex M F Single Married Widowed Separated Divorced

Employed By _____ Occupation _____

How did you hear about our office or who referred you? _____

In case of an emergency, notify _____ Phone _____

Responsible Party Information

The Responsible party is the person filling out this form and must be 18 or older. If the patient is a minor then the parent **who brought the child patient in today is the responsible party; not the insured.** The responsible party cannot be a person who has not physically signed our forms. If you are over 18 and you are the patient please just write "self" below.

Name _____ DOB _____ Age _____
Last First MI

Address _____ City _____ Zip _____

Soc. Sec. # _____ Home # _____ Cell # _____ Wk # _____

Email _____ Relationship to Ins. Subscriber _____

Sex M F Single Married Widowed Separated Divorced

Employed By _____ Occupation _____

Business Address _____ Business Phone _____

Dental Insurance Information

Subscriber Name _____ DOB _____
Last First MI

Soc. Sec. # _____ Subscriber ID # _____

Employer/Group Name _____ Group # _____

Dental Insurance Company Name _____ Phone _____

Secondary Dental Insurance Information

Subscriber Name _____ DOB _____
Last First MI

Soc. Sec. # _____ Subscriber ID # _____

Employer/Group Name _____ Group # _____

Dental Insurance Company Name _____ Phone _____

DENTAL HISTORY

What would you like us to do today? _____ Are you in dental discomfort today? _____

Former Dentist _____ Address _____ Phone _____

Date of last dental visit _____ Date of last x-rays _____

Check (✓) yes or no if you have had problems with any of the following:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Bad breath | <input type="checkbox"/> Y <input type="checkbox"/> N Food collection between teeth | <input type="checkbox"/> Y <input type="checkbox"/> N Periodontal treatment | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to sweets |
| <input type="checkbox"/> Y <input type="checkbox"/> N Bleeding gums | <input type="checkbox"/> Y <input type="checkbox"/> N Grinding or clenching teeth | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to cold | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity when biting |
| <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to hot | <input type="checkbox"/> Y <input type="checkbox"/> N Loose teeth or broken fillings | <input type="checkbox"/> Y <input type="checkbox"/> N Clicking or popping jaw | <input type="checkbox"/> Y <input type="checkbox"/> N Sores or growths in mouth |

How often do you brush your teeth? _____ Floss? _____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? Y N

Other information about your dental health or previous treatment _____

MEDICAL HISTORY

Physician's Name _____ Phone _____

Date of last visit _____ Have you had any serious illnesses or operations? Y N

If Yes, describe _____

Are you currently under physician care? Y N If yes, describe _____

Has a Doctor recommended that you **Premedicate** prior to dental care? Y N _____

Have you ever had a blood transfusion? Y N If yes, give approximate date _____

Have you ever taken Fen-Phen/Redux? Y N

Women: Are you pregnant? Y N Nursing? Y N Taking birth control pills? Y N

Check (✓) yes or no whether you have had any of the following:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N AIDS/HIV Positive | <input type="checkbox"/> Y <input type="checkbox"/> N Cough, persistent | <input type="checkbox"/> Y <input type="checkbox"/> N Jaw Pain | <input type="checkbox"/> Y <input type="checkbox"/> N Shortness of breath |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anaphylaxis | <input type="checkbox"/> Y <input type="checkbox"/> N Coumadin | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney disease | <input type="checkbox"/> Y <input type="checkbox"/> N Sinus Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N Liver Disease | <input type="checkbox"/> Y <input type="checkbox"/> N Skin rash |
| <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis, Rheumatism | <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N Material Allergies (Latex) | <input type="checkbox"/> Y <input type="checkbox"/> N Spina Bifida |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial heart valves | <input type="checkbox"/> Y <input type="checkbox"/> N Fainting | <input type="checkbox"/> Y <input type="checkbox"/> N Mitral valve prolapse | <input type="checkbox"/> Y <input type="checkbox"/> N Stroke |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial joints | <input type="checkbox"/> Y <input type="checkbox"/> N Food allergies | <input type="checkbox"/> Y <input type="checkbox"/> N Nervous problems | <input type="checkbox"/> Y <input type="checkbox"/> N Stomach Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma | <input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker/Hear Surgery | <input type="checkbox"/> Y <input type="checkbox"/> N Surgical Implant |
| <input type="checkbox"/> Y <input type="checkbox"/> N Atopic (allergy prone) | <input type="checkbox"/> Y <input type="checkbox"/> N Headaches | <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric care | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Back problems | <input type="checkbox"/> Y <input type="checkbox"/> N Heart murmur | <input type="checkbox"/> Y <input type="checkbox"/> N Rapid weight gain or loss | <input type="checkbox"/> Y <input type="checkbox"/> N Tobacco habit |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood disease | <input type="checkbox"/> Y <input type="checkbox"/> N Heart problems if yes describe: _____ | <input type="checkbox"/> Y <input type="checkbox"/> N Radiation treatment | <input type="checkbox"/> Y <input type="checkbox"/> N Tonsillitis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer | <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia – bleeding | <input type="checkbox"/> Y <input type="checkbox"/> N Respiratory disease | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chemical dependency | <input type="checkbox"/> Y <input type="checkbox"/> N Herpes | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic/Scarlet fever | <input type="checkbox"/> Y <input type="checkbox"/> N Ulcer/Colitis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chemotherapy | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis | | <input type="checkbox"/> Y <input type="checkbox"/> N Venereal disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cortisone treatments | <input type="checkbox"/> Y <input type="checkbox"/> N High blood pressure | | |

Is patient currently taking any medications? If yes list all:

Does patient have drug allergies? Penicillin/Codeine If yes, list all:

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist. I authorize the dental insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payments of benefits. **I understand that I am financially responsible for all charges whether or not paid by my insurance.** Payment is due in full at time of treatment.

Signature _____

Date _____