Spectrum Dental & Prosthodontics

Name_____Pref. Name_____ SS#_____Today's Date_____

Date of Birth_____Age___Sex M F If Minor, Parent's Name_____

Address_____

City_____ State_____Zip Code_____

Cell Phone_____Home Phone_____E-mail_____

Occupation_____ Employed By_____

Marital Status (circle) M S W D Spouse's Name_____

Spouse's Occupation_____Employed By_____

Person Responsible for This Account_____

Whom may we thank for referring you?_____

Emergency Contact _____Relation_____Phone Number_____

DENTAL INSURANCE- Payment is due at the time of service. Please provide us with a copy of your insurance card(s) and we can make a copy, or you may complete all of the following information.

Primary **Dental** Insurance Company_____Member ID#_____Group # _____

Address_____ Phone #_____

Policyholder_____ SS#_____Date of Birth_____

Secondary Dental Insurance Company_____Member ID#_____Group#_____

Address_____ Phone #_____

Policyholder_____ SS#_____Date of Birth_____

DENTAL HISTORY

Purpose of your visit?_____

Have you had any problems with previous dental treatment?_____

_____

Check if you have had problems with the following:

- ❑ Bad taste in your mouth
- ❑ Bad odor in your mouth
- ❑ Discomfort in head or face
- ❑ Grinding your teeth
- ❑ Loose teeth
- ❑ Broken fillings
- ❑ Periodontal treatment
- ❑ Sensitive to hot/cold
- ❑ Sensitive to biting
- ❑ Bleeding Gums
- ❑ Clicking or popping of jaw
- ❑ Swelling or bumps
- ❑ Food collecting between teeth

Are you dissatisfied with your teeth and their appearance? YES NO
Do you feel that in the past you required a lot of dental work? YES NO
Do any of your family members wear dentures? YES NO
Do you feel you will eventually lose teeth and wear dentures? YES NO

CONFIDENTIAL MEDICAL HISTORY

Primary Care Physician's Name_____ Date of last visit_____

Have you been hospitalized in the last 2 years? If yes, please explain_____

_____

MEDICATIONS

List your current medications_____

_____

Check if you have allergic reactions to any of the following:

- ❑ Aspirin
- ❑ Penicillin
- ❑ Barbiturates
- ❑ Codeine
- ❑ Sulfa
- ❑ Anesthetics
- ❑ Other_____

Check if you have or have had any of the following:

- ❑ Aids
- ❑ Cortisone Treatments
- ❑ Heart Attack
- ❑ Angina
- ❑ Artificial Valves
- ❑ Heart Murmur
- ❑ Anemia
- ❑ Arthritis
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Back Problems
- ❑ Blood Disease
- ❑ Cancer
- ❑ Chemical Dependency
- ❑ Persistent Cough
- ❑ Cough up Blood
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Glaucoma
- ❑ Headaches
- ❑ Circulatory Problems
- ❑ Hepatitis
- ❑ HIV Positive
- ❑ High Blood Pressure
- ❑ Jaundice
- ❑ Kidney Disease
- ❑ Mitral Valve Prolapse
- ❑ Chemotherapy
- ❑ Nervous Problems
- ❑ Pacemaker
- ❑ Psychiatric Care
- ❑ Radiation Treatment
- ❑ Respiratory Disease
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Shortness Breath
- ❑ Sinus Problems
- ❑ Stroke
- ❑ Skin Rash
- ❑ Swelling Feet
- ❑ Swollen Glands
- ❑ Thyroid Disease
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Venereal Disease
- ❑ Current Smoker
- ❑ Past Smoker
- ❑ A-Fib
- ❑ Parkinsons Disease

Please list any serious operations you have had_____

Have you ever had a serious accident?_____

Have you ever had bleeding or other problems following dental treatment?_____

_____

Do injuries and cuts take longer than 2 weeks to heal? YES/ NO

Do you pre-medicate before dental appointments? YES/ NO

Women Only*

*Are you Pregnant? YES / NO *Nursing? YES / NO *Taking Birth Control? YES / NO *Have osteoporosis? YES / NO

Consent: The information on both pages is correct, to the best of my knowledge. I give my consent to have the necessary treatment recommended for my (or my minor's) dental needs, after it has been mutually approved. I will not hold my dentist or his/her staff liable for any errors that I may have made while completing this form. I understand that my insurance policy is an agreement between my insurance company and myself. I am aware that I will be responsible for any fees not covered by my insurance plan.

DATE_____SIGNATURE_____

DATE_____PROVIDER'S SIGNATURE_____