Heber Springs Dental Care

Date_________________________

PATIENT INFORMATION

Name____ Birthdate______________ Phone____________________

Address____ City/State_____________________ Zip_______________

E-mail____ SS#_________________________________

Emergency contact name______________________________________ Emergency contact phone_________________________

DENTAL HISTORY

Reason for today's visit____ Date of last dental care______________

Mark (X) if you have had problems with any of the following:

	Bad Breath		Headaches		Sensitivity to heat or cold
	Bleeding gums		Grinding teeth		Sensitivity to sweets
	Clicking or popping jaw		Loose teeth or broken fillings		Sensitivity when biting
	Food collection between teeth		Tooth discoloration		Sores or growths in your mouth

How often do you brush?____________________________ How often do you floss?_____________________________

On a scale of 1-10, how **happy** are you with your smile? **(circle): 1 2 3 4 5 6 7 8 9 10**

Would you like to change anything about your smile? **(circle): Yes No**

If yes, What would you like to see differently with your smile? **(circle below):**

Whiter teeth **Straighter teeth** **Replace missing teeth** **other:**______________________________

MEDICAL HISTORY

Have you had any serious injuries, illnesses, or operations? **(circle): Yes No** If yes, Please describe__________________________

Have you ever had an artificial joint or heart replacement? **(circle): Yes No** If yes, please describe__________________________

Do you snore/ have you been diagnosed with sleep apnea? **(circle): Yes No** Do you currently wear a C-pap? **(circle): Yes No**

Are you currently pregnant? **(circle): Yes No** Are you on birth control? **Yes No** Are you currently breastfeeding? **Yes No**

Mark (X) to indicate if you have had any of the following:

	Artificial heart valves		Epilepsy or Seizures		Mitral valve prolapse		Tuberculosis
	Artificial joints, pins, etc.		Fainting		Pacemaker		Ulcers
	Blood disease/transfusion		Heart problems		Respiratory disease		Venereal disease
	Cancer		Hepatitis		Shortness of breath		STDs
	Chemical dependency		High blood pressure		Stroke		Infectious disease
	Chemotherapy		HIV/AIDS		Thyroid problems		Sleep apnea
	Diabetes		Kidney or liver disease		Tobacco habits		Autoimmune disorder

List medications you are currently taking and the correlating diagnosis:____

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Allergies: ____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with __________________________________and assign directly to Dr.________________________________all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named dentist may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of responsible party____ Date_________________________

Print name of responsible party____ Relationship to patient____________________

Please a copy of your insurance card to front desk if applicable