NORTHERN PEAKS DENTAL

A New Way of Doing Dentistry

Patient Information

First Name: _____ MI: _____ Last Name: _____ Gender: M F

Mailing Address: _____ Birthdate: _____

City/State/Zip _____ SSN: _____

Home Phone _____ Cell: _____ Marital Status: _____

Email: _____ Do you prefer (circle one): Texts Emails None

Responsible Person (if under age 18):

First Name: _____ MI: _____ Last Name: _____ Gender: M F

Relationship to Patient: _____ Address (if different): _____

DOB: _____ SSN: _____ _____

Phone Number: _____

Emergency Contact Information:

Name: _____ Relationship: _____

Contact's Phone Number: _____

Insurance Information

Do you have dental insurance? Yes or No

Insurance Company: _____

Subsciber's Name: _____ Subscriber's DOB: _____

Subscriber ID/Policy #: _____ Group #: _____

Employer: _____

How did you hear about our office? _____

Health History

Current Family Physician: _____ Phone Number: _____

Please list any current medications: _____

_____

_____

Do you have or have you ever had any of the following?

___ Arthritis
___ Joint
___ Replacement/Implant
___ Organ Transplant
___ Asthma – Inhaler
___ Emphysema
___ Respiratory Problems
___ Easily Winded
___ Hay Fever/Allergies
___ Chew/Smoke Tobacco
___ Cold Sores/Herpes
___ Glaucoma
___ Stroke
___ Epilepsy
___Dizziness
___ Fainting
___ Head Injuries
___ Mental Disorders
___ Drug/Alcohol Addiction
___ Kidney Disease
___ Diabetes
___ Liver Disease
___ Hepatits – A or B
___ Aids/HIV
___ Caner
___ Growths/Tumors
___ Artifical Heart Valve
___ Heart Attack
___ Heart Murmur
___ High Blood Pressure
___ Low Blood Pressure
___ Pacemaker
___ Rheumatic Fever
___ Heart Disease
___ Chest Pains
___ Anemia
___ Hemophilia
___Blood Disease
___ Blood Transfusion
___ Blood Clots
___ Pain/Noise in Jaw Joints
___ Pregnancy: Past or Present
___ Thyroid Problems
___ Stomach Problems
___ Ulcers
___ Recent Weight Loss
___ Frequently Tired
___ Radiation Treatment
___Chemotherapy
___ Other:

Do you have any allergies to any of the following:

___ Ibuprofen
___ Aspirin
___ Tylenol
___ NSAIDS
___ Penicillin
___ Amoxicillin
___ Tetracycline
___ Erythromycin
___ Zithromax
___ Azithromycin
___ Hydrocodone
___ Codiene
___ Morphine
___ Barbituates
___ Sedatives
___ Local Anesthetics
___ Iodine
___ Sulfa Drugs
___ Metals
___ Latex Rubber
___None
___ Other: Please list below

Have you taken any bone density medications such as Fosamax, Boniva, or another such as these?

Yes or No. If yes, which medication? _____

Have you ever taken a medication for weight loss such as Fen-Phen or another?

Yes or No. If yes, which medication? _____

Dental History

Who is your previous Dentist? _____ Office Name: _____

When was your dental exam? _____

When was your last cleaning? _____

Would you like records sent over from your previous dentist? _____

Are you having any problems with your teeth now? Yes or No

Please describe. _____

_____

_____

Personal History – Please answer yes or no

Are you concerned about the appearance of your teeth? _____

Have you had any cavities within the past two years? _____

Do you avoid or have difficulty chewing on hard foods? _____

Do you clench your teeth in the daytime? _____

Do you wear or have you ever worn a bite appliance? _____

Do your gums bleed when bushing or flossing? _____

Have you ever been told you have gum recession? _____

Have you ever been treated for or been told you have gum disease? _____

Have you ever had braces, orthodontic treatment or spacers? _____

Do you have problems with your jaw joint? (TMJ, popping, clicking, etc.) _____

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