PERKINS DENTAL NEW PATIENT FORM VAUGHN E. PERKINS III,DMD

PATIENT INFORMATION (CONFIDENTIAL)

NAME _____ DATE _____
FIRST MI LAST

ADDRESS _____ CITY _____ STATE _____ ZIP _____

SOC SEC # _____ BIRTHDATE _____ HOME PHONE _____

WORK PHONE _____ CELL PHONE _____ PAGER # _____

EMAIL ADDRESS _____

SPOUSE OR PARENT'S NAME _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

CHILDREN'S INFORMATION

NAME	BIRTHDATE	NAME	BIRTHDATE
NAME	BIRTHDATE	NAME	BIRTHDATE

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE _____

SOC SEC # _____ DRIVER'S LICENSE # _____ BIRTHDATE _____

EMPLOYER _____ WORK PHONE _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

DENTAL INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SOCIAL SECURITY NUMBER _____

NAME OF EMPLOYER _____

INSURANCE CO _____ GRP# _____ POLICY/ID# _____

INS CO ADDRESS _____ CITY _____ STATE _____ ZIP _____

INS CO PHONE _____

ALL SERVICES ARE TO BE PAID IN FULL AT THE TIME OF SERVICE UNLESS PREVIOUS ARRANGEMENTS ARE MADE.

I GIVE PERMISSION FOR ANY PHOTOGRAPHS TAKEN OF ME TO BE USED IN PROFESSIONAL PRESENTATIONS OR JOURNALS.

I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION, INCLUDING DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME DURING THE PERIOD OF SUCH DENTAL CARE, TO THIRD PARTY PAYORS AND/OR HEALTH PRACTITIONERS.

I HAVE RECEIVED AND WILL/HAVE REVIEWED THIS OFFICE'S PRIVACY POLICY.

_____ _____

Signature of Patient or Parent if Minor Date

PATIENT'S NAME_____ DATE_____

WHY HAVE YOU COME TO SEE US TODAY?_____

WHEN WAS YOUR LAST DENTAL VISIT?_____ WHAT WAS DONE THEN?_____

_____

PREVIOUS DENTIST (NAME AND LOCATION) (OPTIONAL)_____

HAVE YOU HAD A COMPLETE SERIES OF DENTAL FILMS (XRAYS) TAKEN? WHEN, WHERE?_____

HOW OFTEN DO YOU BRUSH YOUR TEETH?_____

HOW OFTEN DO YOU FLOSS YOUR TEETH?_____

PLEASE CHECK ONE BOX

	YES	NO
DO YOUR GUMS BLEED WHILE YOU ARE BRUSHING OR FLOSSING?	☐	☐
ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS?	☐	☐
ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS?	☐	☐
DO YOU FEEL PAIN TO ANY OF YOUR TEETH?	☐	☐
DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?	☐	☐
HAVE YOU HAD ANY HEAD, NECK, OR JAW INJURIES?	☐	☐
HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?		
CLICKING?	☐	☐
PAIN(JOINT, EAR, SIDE OF FACE)	☐	☐
DIFFICULTY IN OPENING OR CLOSING	☐	☐
DIFFICULTY IN CHEWING	☐	☐

	YES	NO
DO YOU HAVE FREQUENT HEADACHES?	☐	☐
DO YOU CLENCH OR GRIND YOUR TEETH?	☐	☐
HAVE YOU NOTICED ANY LOOSENING OF YOU TEETH?	☐	☐
DOES FOOD TEND TO BECOME CAUGHT BETWEEN YOUR TEETH?	☐	☐
HAVE YOU EVER HAD PERIODONTAL TREATMENT (GUMS)?	☐	☐
HAVE YOU WORN A BITE PLATE OR OTHER APPLIANCE?	☐	☐
HAVE YOU HAD ANY DIFFICULT EXTRACTIONS IN THE PAST?	☐	☐
HAVE YOU HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS?	☐	☐
DO YOU WEAR DENTURES OR PARTIALS?	☐	☐
IF YES, DATE OF PLACEMENT?_____		

IF YOU COULD CHANGE <u>ANYTHING</u> ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE?

_____

_____

_____

NOTES:_____

_____

PATIENT'S NAME_____ DATE_____

	YES	NO
1. ARE YOU IN GOOD HEALTH?	☐	☐
2. HAVE THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR?	☐	☐
3. DATE OF YOUR LAST PHYSICAL EXAM:_____		
4. PHYSICIAN'S NAME:_____ ADDRESS:_____ PHONE NO:_____		
5. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS?	☐	☐
PLEASE EXPLAIN:_____ _____		
6. ARE YOU TAKING ANY MEDICINE(S) INCLUDING NON-PRESCRIPTION MEDICINE	☐	☐
IF YES, WHAT MEDICINE(S) ARE YOU TAKING?_____ _____		
7. DO YOU HAVE PROLONGED BLEEDING?	☐	☐
8. HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION?	☐	☐
9. HAVE YOU HAD A RECENT WEIGHT LOSS?	☐	☐
10. HAVE YOU EVER TAKEN FEN-SHEN OR REDUX?	☐	☐
11. DO YOU USE TOBACCO?	☐	☐
12. DO YOU OR HAVE YOU USED CONTROLLED SUBSTANCES?	☐	☐
13. ARE YOU WEARING CONTACT LENSES?	☐	☐
14. DO YOU HAVE ANY DISEASE, CONDITION, OR PROBLEM NOT LISTED ABOVE THAT YOU THINK I SHOULD KNOW ABOUT?	☐	☐
WOMEN ONLY		
ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?	☐	☐
ARE YOU NURSING?	☐	☐
ARE YOU TAKING BIRTH CONTROL PILLS?	☐	☐

PLEASE CHECK ONE BOX

ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO:	YES	NO
LOCAL ANESTHETICS LIKE NOVOCAINE	☐	☐
PENICILLIN OR OTHER ANTIBIOTICS	☐	☐
SULFA DRUGS	☐	☐
BARBITURATES, SEDATIVES, SLEEPING PILLS	☐	☐
CODEINE	☐	☐
ASPIRIN	☐	☐
IODINE	☐	☐
ANY METALS (E.G. NICKEL, MERCURY, ETC.)	☐	☐
LATEX/RUBBER	☐	☐
OTHER (PLEASE SPECIFY)_____		
DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:		
RHEUMATIC HEART DISEASE OR RHEUMATIC FEVER	☐	☐
SCARLET FEVER	☐	☐
HEART DEFECT OR HEART MURMUR	☐	☐
HEART TROUBLE, HEART ATTACK, OR ANGINA	☐	☐
CHEST PAIN	☐	☐
SHORTNESS OF BREATH	☐	☐
PACEMAKER	☐	☐
HEART SURGERY	☐	☐
HIGH/LOW BLOOD PRESSURE	☐	☐
CONGENITAL HEART PROBLEM	☐	☐
SWELLING OF FEET, ANKLES, HANDS	☐	☐
HEPATITIS, JAUNDICE, OR LIVER DISEASE	☐	☐
STROKE	☐	☐
SINUS TROUBLE	☐	☐
LUNG OR BREATHING PROBLEMS	☐	☐
ASTHMA OR HAY FEVER	☐	☐
HIVES OR SKIN RASH	☐	☐
FAINTING OR DIZZY SPELLS	☐	☐
DIABETES	☐	☐
AIDS OR HIV INFECTION	☐	☐
THYROID PROBLEMS	☐	☐
ALLERGIES	☐	☐
ARTHRITIS OR RHEUMATISM	☐	☐
JOINT REPLACEMENT OR IMPLANT	☐	☐
STOMACH ULCER	☐	☐
KIDNEY TROUBLE	☐	☐
TUBERCULOSIS	☐	☐
PERSISTENT COUGH	☐	☐
COUGH THAT PRODUCES BLOOD	☐	☐
CHEMOTHERAPY (CANCER, LEUKEMIA)	☐	☐
SEXUALLY TRANSMITTED DISEASE	☐	☐
EPILEPSY OR SEIZURES	☐	☐
ANEMIA	☐	☐
GLAUCOMA	☐	☐
NERVOUSNESS	☐	☐
TONSILLITIS	☐	☐
TUMORS	☐	☐
MENTAL HEALTH CARE	☐	☐
BACK PROBLEMS	☐	☐
CHEMICAL DEPENDENCY	☐	☐
MITRAL VALVE PROLAPSE	☐	☐
CORTISONE TREATMENT	☐	☐
COLD SORES/FEVER BLISTERS	☐	☐
HYPOGLYCEMIA	☐	☐
EATING DISORDERS	☐	☐