REDSTONE
DENTAL

Patient Name: ______________________________________ Today's Date: _____ / _____ / _____

☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Other

Social Security #: _______ / _____ / _______ Date of Birth: _____ / _____ / _____ Age: ______

Home # (____) ________________ Work # (____) ______________Ext:_____ Cell # (____) _______________

Drivers License #: ____________________ Email Address: _________________________@____________

Preferred Method of Contact (check all that apply): ☐ Cell ☐ Email ☐ Home ☐ Work ☐ Mail

Street Address: __________________________________ City, State Zip ____________________________

If you're completing this form for someone else what is your relationship to that person?

Your name: _____________________________ Relationship: _________________________

Emergency Contact: _________________________ Relation: _______________ Phone #: (_____) ______________

HEALTH INFORMATION

Do you have or have you ever had any of the following? Please check all that apply. **If none, please check NONE.**

☐ NONE
☐ AIDS / HIV
☐ Seasonal Allergies
☐ Aortic Valve Reg
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Transfusion
☐ Birth Control
☐ Cancer
☐ Codeine Allergy

☐ Diabetes
(A1C = _______)
☐ Dizziness
☐ Alcohol / Drug Addiction
☐ Epilepsy
☐ Fainting
☐ Fever Blisters
☐ Glaucoma
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis _______
☐ High Blood Pressure

☐ Jaundice
☐ Kidney Disease
☐ Latex Allergy
☐ Liver Disease
☐ Mitral Valve Prolapse
☐ Mouth Ulcers
☐ Nervous Disorders
☐ Pacemaker
☐ Penicillin Allergy
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ STD

☐ Sinus Problems
☐ Stomach Ulcers
☐ Stroke
☐ Sulfur Allergy
☐ Tuberculosis
☐ Ulcers
☐ Using Blood Thinner
☐ Using Methadone
☐ Viagra Type Medications
☐ Other
____

Have you been admitted to a hospital or needed emergency care during the past five years? ☐ YES ☐ NO
If yes, please explain: ____

Are you under the care of a physician now? ☐ YES ☐ NO
If yes, please explain: ____

Name of Physician:___________________________________ Phone # (_____) ____________________

Do you have any health problems not listed above or that need further clarification? ☐ YES ☐ NO
If yes, please explain: ____

Do you have any upcoming procedures / surgeries? ☐ YES ☐ NO
If YES, please explain ____

What medications are you currently taking, including any over the counter and herbal medications?
____
____

WOMEN only: Are you pregnant? ☐ YES ☐ NO If yes, Due Date: _____ / _____ / _____

REFERRAL INFORMATION

How did you hear about our office?

☐ Another patient, friend ______________________
☐ Another patient, relative ____________________
☐ Another dental office _______________________
☐ Internet Search
☐ Drive By / Sign
☐ Insurance
☐ Mailer
☐ Billboard
☐ Other _______________

DENTAL HISTORY

Date of your LAST Dental Visit: _____ / _____ / _____ Reason for TODAY'S visit: ______________________________

Have you ever had complications following a dental procedure?	☐ YES	☐ NO
Do your gums bleed when you brush or floss?	☐ YES	☐ NO
Are your teeth sensitive to hot / cold / sweets / pressure?	☐ YES	☐ NO
Do you have dry mouth?	☐ YES	☐ NO
Do you have / wear a denture or partial	☐ YES	☐ NO
Have you had any periodontal (gum) treatments?	☐ YES	☐ NO
Do you use tobacco (smoke, snuff, chew)? If yes, how much a day? _________________	☐ YES	☐ NO
Are you interested in teeth whitening?	☐ YES	☐ NO
Do you require pre-medication prior to dental work?	☐ YES	☐ NO

EMPLOYMENT INFORMATION

Employer Name: _________________________________ Phone #: (_____) ______________________

Street Address: _______________________________________ City, State Zip _________________________________

INSURANCE INFORMATION

Primary

Insurance Carrier: ____

Name of Insured: ____ Is Insured a patient? ☐ YES ☐ NO

Insured's Birth Date: _____ / _____ / _____ Group #: _______________________________

Insured's Social Security #: _______ / _______ / _______ Member ID: ___________________________________

Insured's Employer: ______________________________________

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other __________________

Secondary

Insurance Carrier: ____

Name of Insured: ____ Is Insured a patient? ☐ YES ☐ NO

Insured's Birth Date: _____ / _____ / _____ Group #: _______________________________

Insured's Social Security #: _______ / _______ / _______ Member ID: ___________________________________

Insured's Employer: ______________________________________

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other __________________

I certify that I have read and understand the above and that the information provided on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information when treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

____ Date: _____ / _____ / _____

Signature of Patient or Legal Guardian