Summer Creek Dental

Welcome to Summer Creek Dental. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following forms. The information provided on this form is important to your dental health. If you have any questions, please don't hesitate to ask.

PATIENT INFORMATION			
Patient's Last name:	**First name:**	**Date of Birth:**	
Address:			
Social Security #:	**Home phone #:**	**Cell phone #:**	
Occupation:	**Employer:**	**Employer phone #:**	
E-mail address:			
Referred to us by: **Flyer/Brochure External Sign Insurance Company Family/Friend _____ Other_____**			

INSURANCE INFORMATION			
Primary Dental Insurance Name:			
Subscriber's name:	**Subscriber's DOB:**	**SS# or Subscriber ID:**	**Group or Policy #:**
Occupation:	**Employer:**	**Employer phone #:**	**Secondary Phone #:**
Patient's relationship to subscriber:			
Name of secondary insurance (if applicable):	**Subscriber's name:**	**Subscriber's Date of Birth:**	**Group #:**

IN CASE OF EMERGENCY			
Emergency Contact Name:	**Relationship to Patient:**	**Phone #:**	**Secondary Phone #:**

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check all that apply)

Heart problems

- ☐ NONE
- ☐ Heart ailment or angina
- ☐ Chest pain
- ☐ Heart murmur, mitral valve prolapse, heart defect
- ☐ Shortness of breath
- ☐ Rheumatic fever or rheumatic heart disease
- ☐ Artificial valve
- ☐ Pacemaker
- ☐ High or low blood pressure

Blood problems

- ☐ NONE
- ☐ Anemia or blood disorders
- ☐ Abnormal bleeding after extractions or surgery
- ☐ Easy bruising
- ☐ Ever required a blood transfusion?
  If so, date_____

Intestinal Problems

- ☐ NONE
- ☐ Ulcers
- ☐ Weight gain or loss
- ☐ Kidney disease
- ☐ Stomach problems

Bone or Joint problems

- ☐ NONE
- ☐ Arthritis
- ☐ Back or neck pain
- ☐ Joint replacement (total hip, pins or implants)

Other

- ☐ NONE
- ☐ Epilepsy, seizures, or fainting spells
- ☐ Stroke(s)
- ☐ Migraine headaches or frequent headaches
- ☐ Thyroid problems
- ☐ Persistent cough or swollen glands
- ☐ Cancer/Tumor(s)
- ☐ Asthma
- ☐ Diabetes
- ☐ Hepatitis or other liver disease
- ☐ Tuberculosis or other lung problems
- ☐ AIDS or HIV positive
- ☐ Neurologic condition or Epilepsy
- ☐ Drink alcohol
  If so, how much? _____
- ☐ Smoke or use chewing tobacco
  If so, how much? _____
- ☐ History of alcohol or drug abuse
- ☐ Premedications required by physician

Are you allergic to, or have you reacted adversely to any of the following?

- ☐ NO known drug allergies (NKDA)
- ☐ Latex materials
- ☐ Ibuprofen, Naproxen
- ☐ Penicillin or other antibiotics
- ☐ Local anesthetics
- ☐ Codeine or other narcotics
- ☐ Sulfa drugs
- ☐ Barbiturates, sedatives, or sleeping pills
- ☐ Aspirin
- ☐ Other:_____

Are you currently taking any of the following?

- ☐ NONE
- ☐ Aspirin
- ☐ Anticoagulants (blood thinners)
- ☐ High blood pressure medicine
- ☐ Ibuprofen, Naproxen
- ☐ Antidepressants or tranquilizers
- ☐ Insulin, Orinase, or other diabetes drug
- ☐ Nitroglycerin
- ☐ Cortisone or other steroids
- ☐ Osteoporosis (bone density) medication

Please list all medications you are currently taking:_____

_____

_____

Women

- ☐ NONE
- ☐ Pregnant or think you may be pregnant
  Expected delivery date: _____
- ☐ Currently nursing
- ☐ Taking hormones or contraceptives

Do you have any disease, condition, or problem not listed above? _____

_____

_____

_____ Initials

DENTAL HEALTH HISTORY

Please check all that may apply to you.

- ☐ **NONE**
- ☐ Apprehensive about dental treatment
- ☐ Problems with previous dental treatment
- ☐ Gag easily
- ☐ Wear dentures
- ☐ Food that catches between your teeth
- ☐ Difficulty in chewing your food or only chew on one side of your mouth
- ☐ Gums that bleed when you brush or floss
- ☐ Swollen or tender gums
- ☐ Slow healing sores in or around your mouth
- ☐ Sensitive teeth

Do you feel twinges of pain when your teeth come in contact with:

- ☐ Hot foods or liquids
- ☐ Cold foods or liquids
- ☐ Sours
- ☐ Sweets

- ☐ Taking fluoride supplements
- ☐ Dissatisfied with the appearance of your teeth
- ☐ Jaw makes noise that bothers you or others
- ☐ Clench or grind your teeth frequently
- ☐ Jaw that feels tired
- ☐ Jaw that gets stuck so that you can't open freely
- ☐ Pain when you chew/open to take a bite
- ☐ Pain or headaches upon waking
- ☐ Diagnosed with TMD/TMJ
- ☐ Unable to open your mouth fully
- ☐ Uncomfortable bite
- ☐ Previous trauma to the jaw

Do you have any other condition or problem not listed above? _____

_____

_____

How often do you brush? _____

How often do you floss? _____

Consent

I acknowledge that the above information is true to the best of my knowledge. I authorize my insurance benefits (if applicable) be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Summer Creek Dental and/or my insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian Signature Date