OrthodonticSmilemaker

ROGER B. ELTON DDS, MSD

Kids love us, parents and dentists trust us.

Welcome To Our Office!
So That We Might Become Better Acquainted Please Complete The Following:

*Patients Name:*_____ *Nickname:*_____ *DATE*_____

*Street*_____ *City*_____ *Zip:*_____

*Sex*_____ *Age:*_____ *Date of Birth:*_____ *Home Phone*_____

*Children: School*_____ *Activities:*_____

*Adult Marital Status: Single:*__ *Married:*__ *Divorced:*__ *Remarried:*__

*Referred By*_____ *Patients Dentist*_____

*Date Of Last Visit For A Cleaning & Examination*_____

RESPONSIBLE PARTY INFORMATION

*First Name & Initial*_____ *Last Name*_____

*Address*_____ *City*_____ *State*___ *Zip*_____

Home Telephone(____)____-_____ Single__ Married__ Divorced__ Remarried__

*Occupation*_____ *Employer*_____ *Wrk #*_____

*O.K. to contact at work? Yes___ No ___ Insured Date of Birth*_____

*Insurance Company #1*_____ *Policy Holder*_____

*ID Number*_____ *Social Security #___-__-____ Group #*_____

*Insurance Company #2*_____ *Policy Holder*_____

*ID Number*_____ *Social Security #___-__-____ Group #*_____

Note: An adult presenting for treatment assumes ultimate financial responsibility regardless of insurance coverage or another party's agreement to pay for such treatment.

An adult accompanying a minor child to our office assumes ultimate responsibility for treatment charges in the event of non-payment by an other wise legally-responsible party.

*Please give a brief description of the reasons for your visit*_____

_____

HEALTH HISTORY

Patient Name_____

It is important that we know about your medical history. Many things have a direct bearing on your dental health. We will review the questionnaire and discuss it with you in detail. Information you give is strictly confidential and will not be released to anyone without your written permission.

Physician's name_____Date of last physical exam_____
In case of emergency notify_____Phone number (___)___-____
Nearest relative_____Phone number (___)___-____
Address_____City_____State____Zip_____

Circle any of the following which the patient has had or now has:

Heart Disease	Asthma	Drug Addiction	Angina Pectoris
Hay Fever	Hemophilia	Sinus Trouble	High Blood Pressure
Heart Murmur	Allergies	Ulcers	Bruises Easily
Rheumatic Fever	Diabetes	Anemia	Congenital Heart
Thyroid Disease	Arthritis	Cancer	Disease
Scarlet Fever	Stroke	Liver Disease	Artificial joint
Rheumatism	Hepatitis A	Hepatitis B	Kidney Trouble
Yellow Jaundice	Aids	Glaucoma	Excessive Bleeding
Sickle Cell	Emphysema	Chronic Cough	Venereal Disease
Cold Sores	Hives	Heart Surgery	Excessive Bleeding
X-ray/Cobalt Treatment		Epilepsy/Seizures	Artificial Heart Valve
Cortisone Medication		Heart/Pacemaker	
Pain/Noises In Jaw Joints			NONE OF THE ABOVE

Please explain any disease or conditions circled above_____
_____

Does/did the patient ever suck a finger, lip or the tongue? yes no
Does the patient grind or clench the teeth at night? yes no
Does the patient frequently breathe through the mouth? yes no
Has the patient been treated for respiratory problems? yes no
Has the patient been hospitalized or under a phycians care in the last (2) years? Explain_____
Has the patient ever experienced trauma to the head,face, jaw, or teeth? Explain_____
Please list any medications taken in the past(2)years_____
_____
Please list any medications the patient is allergic to_____
_____
Please list and explain any disease or condition not listed_____
_____
Does the patient have any conditions such as:
Mitral valve prolapse, repaired cardiac septal defects or artificial heart valves that require premeditation with antibiotics for dental procedure's? yes no

Women: Are you pregnant? Yes___ No___ Are you taking Bisphosphonates? Yes___ No___
Are you taking medication for Osteopenia or Osteoporosis? yes__ no__
Is there anything else regarding your past or present health that should be documented in your health history? yes__ no__ Explain _____
_____

_____ _____
SIGNATURE OF PATIENT, PARENT, OR GUARDIAN DATE