PATIENT INFORMATION

Date _____

ideal dentistry

PATIENT INFORMATION

☐ Mr. ☐ Ms. ☐ Mrs.	LAST NAME	FIRST	MIDDLE	SEX:	☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED
HOME ADDRESS	CITY	STATE		BIRTHDAY	AGE
EMAIL		CELL PHONE		HOME TELEPHONE	
PATIENT S.S #		DRIVERS LIC. #			

EMPLOYER INFORMATION

OCCUPATION		EMPLOYER	
EMPLOYER ADDRESS	CITY	STATE	WORK PHONE

FINANCIAL RESPONSIBILITY

NAME OF FINANCIALLY RESPONSIBLE PARTY	NAME OF INSURANCE PLAN	GROUP NAME
GROUP #	INSURED S.S. #	BIRTH DATE OF INSURED

HOW DID YOU HEAR ABOUT US?

DENTAL HISTORY

Reason for today's visit: _____

Are you currently in pain? _____

Date of last dental care & X-Rays: _____ Date of last cleaning: _____

Do you have any amalgam (metal) fillings? _____ If yes, how many? _____

Have you had any amalgam fillings and had them removed? _____ When? _____

Do you have any root canal? _____ If yes, how many? _____ How old? _____

Have you had any gold crowns or fillings? _____ If yes, how many? _____

Have you had oral cancer screening? _____

How often do you floss? _____How often do you brush? _____

SYMPTOMS

- ☐ bad breath
- ☐ bleeding gums
- ☐ clicking/popping jaw
- ☐ food between teeth
- ☐ grinding teeth
- ☐ periodontal treatment
- ☐ sensitive to cold/hot
- ☐ sensitive to sweet
- ☐ yellow & discolored
- ☐ loose teeth/broken filling

Emergency Contact _____Phone # _____ Relation to Patient_____

MEDICAL HISTORY

YES NO	YES NO	YES NO
☐ ☐ Are you pregnant	☐ ☐ Kidney or Liver Disease	☐ ☐ Cancer
☐ ☐ Angina	☐ ☐ Hepatitis	☐ ☐ Acid Reflux/Heartburn
☐ ☐ High Blood Pressure	☐ ☐ Thyroid Disorder	☐ ☐ Bleeding Problems
☐ ☐ Heart Murmur	☐ ☐ Been on Fen Fen	☐ ☐ Hepatitis/Liver Disease
☐ ☐ Defective Heart Valve	☐ ☐ Seizures	☐ ☐ TB/Lung Disease
☐ ☐ Pacemaker	☐ ☐ Fainting or Dizziness	☐ ☐ AIDS / HIV+
☐ ☐ Heart Disease	☐ ☐ Rheumatoid Arthritis	☐ ☐ VD/Herpes
☐ ☐ Mitral Valve Prolapse	☐ ☐ Tuberculosis	☐ ☐ Artificial Joints
☐ ☐ Diabetes/Prediabetes	☐ ☐ Blood Disease	☐ ☐ Trouble falling asleep at night
☐ ☐ Rheumatic Fever	☐ ☐ Anemia	☐ ☐ Sleep apnea
☐ ☐ Asthma, Breathing Problem	☐ ☐ Frequent Headaches	☐ ☐ Snore at night
☐ ☐ Osteoporosis/Osteopenia	☐ ☐ Kidney Disease	☐ ☐ Radiation/Chemotherapy
☐ ☐ Psychiatric Care	☐ ☐ Asthma/COPD/Respiratory Issues	☐ ☐ Blood Thinners (Plavix, Elaquis, Coumadin)
☐ ☐ Smoking _____ FREQUENCY	☐ ☐ Alcohol _____ FREQUENCY	☐ ☐ Recreational Drugs _____ FREQUENCY
☐ ☐ Vitamin D deficiency	☐ ☐ Bisphosphonates (post or present) (Fosamax, Boniva, Reclast, Actonel)	

Are you allergic to:

☐ Local Anesthetic ☐ Aspirin ☐ Codeine ☐ Latex
☐ Erythromycin ☐ Penicillin ☐ Sulfa ☐ Other _____

Drugs presently taking _____

Family Physician: _____ Phone #_____
Have you been under a physician's care during the past 2 years? List any previous surgeries (please describe)
_____

_____
Please list any other health or dental condition we should be aware of: _____
_____

_____

I have read the above questionnaire in its entirety and have answered all questions truthfully to the best of my knowledge. I hereby authorize the dentist(s) in charge to perform any and all treatment for my child or myself (if patient is minor). I also consent to such methods as x-rays, drugs, and agents as may be indicated in connection with treatment. The consent will remain in effect until cancelled. I hereby authorize payment directly to iDeal Dentistry unless other written arrangements have been mane prior to treatment. I understand that I am financially responsible for the charges not covered by my insurance plan. I hereby authorize release of any information relating to myself or dependent child, to be shared with any facility in order to obtain benefits and/or payment. I also understand that payment is expected for service rendered at this office upon the first visit. In the event, payments are not received by the agreed upon dates, I understand that 1.5% finance charge (18% APR) may be added to my balance, in addition to any collection charges or legal fees. I also understand that I will be charged a fee of $50.00 at this facility should I not notify this office of my cancellation without a 24 hour notice.

Date:_____ Signature: _____ Dentist: _____

YEAR 2 UPDATE DATE_____	YEAR 3 UPDATE DATE_____
The above health history is true & accurate _____	The above health history is true & accurate _____
I have had following changes in my health/ medication:	I have had following changes in my health/ medication:
_____	_____
Pt. _____ Dr. _____	Pt. _____ Dr. _____