COLUMBIA PRIME DENTAL
CONFIDENTIAL

PATIENT INFORMATION

(PLEASE PRINT CLEARLY) SOCIAL SECURITY NUMBER _______-_______-________

(PLEASE CHECK BOX) MALE ☐ or FEMALE ☐

NAME ______________________________ BIRTHDATE ____________ HOME PHONE ________________

FIRST MI LAST

CELL PHONE NUMBER ______________________ EMAIL ADDRESS ______________________________

ADDRESS __________________________________ CITY ________________ STATE ______ ZIP __________

CHECK ONE: _____ MINOR _____ SINGLE _____ MARRIED _____ DIVORCED _____ WIDOWED _____ SEPARATED_____

IF PATIENT IS A STUDENT, NAME OF SCHOOL/COLLEGE: ____

PERSON TO CONTACT IN CASE OF AN EMERGENCY ____________________________ PHONE ________________

WHOM MAY WE THANK FOR REFERRING YOU? ____

INSURANCE INFORMATION / RESPONSIBLE PERSON FOR THIS ACCOUNT

NAME OF INSURED_____________________________________ RELATIONSHIP TO PATIENT _____________

FIRST MI LAST

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? (Check one) YES ☐ NO ☐

BIRTHDATE _____________ SSN ____________________ DATE EMPLOYED ____________________

EMPLOYER _____________________________________ WORK PHONE ________________________

BUSINESS ADDRESS ______________________________ CITY ______________ STATE _____ ZIP _________

INSURANCE COMPANY ____________________ GROUP # ________________ UNION OR LOCAL # __________

INSURANCE CO. ADDRESS ___________________________ CITY ______________ STATE _____ ZIP _______

HOW MUCH IS YOUR DEDUCTIBLE? $__________ HOW MUCH HAVE YOU USED? $________ MAX ANNUAL BENEFIT? $________

SECONDARY INSURANCE INFORMATION

NAME OF INSURED_____________________________________ RELATIONSHIP TO PATIENT _____________

FIRST MI LAST

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? (Check one) YES ☐ NO ☐

BIRTHDATE _____________ SSN ____________________ DATE EMPLOYED ____________________

EMPLOYER _____________________________________ WORK PHONE ________________________

BUSINESS ADDRESS ______________________________ CITY ______________ STATE _____ ZIP _________

INSURANCE COMPANY ____________________ GROUP # ________________ UNION OR LOCAL # __________

INSURANCE CO. ADDRESS ___________________________ CITY ______________ STATE _____ ZIP _______

HOW MUCH IS YOUR DEDUCTIBLE? $__________ HOW MUCH HAVE YOU USED? $________ MAX ANNUAL BENEFIT? $________

FORM CONTINUES ON THE BACK OF THE PAGE

PATIENT MEDICAL HISTORY

PHYSICIAN ______________________________ OFFICE PHONE ____________________ DATE OF LAST EXAM ________________

	YES	NO
1. ARE YOU UNDER MEDICAL TREATMENT NOW?	☐	☐
2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SERIOUS INJURY OR OPERATION	☐	☐
3. ARE YOU TAKING ANY MEDICATION (S) INCLUDING NON-PRESCRIPTION MEDICINE?	☐	☐

IF YES, WHAT MEDICATION(S) ARE YOU TAKING?

____

____

4. DO YOU USE TOBACCO?	☐	☐
5. DO YOU USE ALCOHOL?	☐	☐
6. DO YOU USE COCAINE OR OTHER DRUGS?	☐	☐
7. ARE YOU WEARING CONTACT LENSES?	☐	☐
8. HAVE YOU EVER TAKEN BISPHOSPHONATES FOR OSTEOPOROSIS?	☐	☐

7. ARE YOU ALLERGIC TO, OR HAVE YOU HAD ANY REACTIONS TO, ANY DRUGS? YES ☐ NO ☐

IF YES, PLEASE SPECIFY

____

____

8. WHEN WAS YOUR LAST PHYSICAL? ____________________

9. WOMEN ONLY:	YES:	NO:
A). ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?	☐	☐
B.) ARE YOU NURSING?	☐	☐
C.) ARE YOU ON ANY BIRTH CONTROL	☐	☐

PLEASE INDICATE WHICH OF THE FOLLOWING APPLIES TO YOU. CHECK ONLY IF THE ANSWER YES.

☐ HIGH BLOOD PRESSURE	☐ HEART DISEASE	☐ EASILY WINDED	☐ HIV/AIDS INFECTION
☐ HEART ATTACK	☐ CARDIAC PACEMAKER	☐ STROKE	☐ HEPATITIS/JAUNDICE
☐ RHEUMATIC FEVER	☐ HEART MURMUR	☐ HAY FEVER	☐ SEXUALLY TRANSMITTED DISEASE(S)
☐ SWOLLEN ANKLES	☐ ANGINA	☐ ALLERGIES	
☐ FAINTING	☐ FREQUENTLY TIRED	☐ TUBERCULOSIS	☐ RESPIRATORY PROBLEMS
☐ SEIZURES	☐ ANEMIA	☐ RADIATION THERAPY	☐ ANXIETY/PANIC ATTACKS
☐ ASTHMA	☐ EMPHYSEMA	☐ GLAUCOMA	☐ DENTAL FEAR
☐ LOW BLOOD PRESSURE	☐ CANCER	☐ RECENT WEIGHT LOSS	**OTHER** (PLEASE SPECIFY):
☐ EPILEPSY/CONVULSIONS	☐ ARTHRITIS	☐ LIVER DISEASE	
☐ LEUKEMIA	☐ JOINT REPLACEMENT OR IMPLANT	☐ HEART TROUBLE	____________
☐ DIABETES		☐ KIDNEY DISEASE	
☐ CHEST PAINS	☐ THYROID PROBLEMS	☐ STOMACH TROUBLES/ULCERS	____________

COMMENTS: ____

PATIENT DENTAL HISTORY

PLEASE INDICATE WHICH OF THE FOLLOWING APPLIES TO YOU. CHECK ONLY IF THE ANSWER YES.

- ☐ DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?
- ☐ ARE YOUR TEETH SENSITIVE TO HOT OR COLD FOODS/LIQUIDS?
- ☐ ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR FOODS/LIQUIDS?
- ☐ DO YOU FEEL PAIN FROM ANY OF YOUR TEETH? PLEASE EXPLAIN: ______________________________
- ☐ DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH? PLEASE SPECIFY WHICH: ____________________
- ☐ HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES? PLEASE SPECIFY WHICH: ____________________
- ☐ HAVE YOU EVER EXPERIENCED CLICKING IN YOUR JAW?
- ☐ HAVE YOU EXPERIENCED PAIN IN YOUR JAW (JOINT, EAR, OR SIDE OF FACE PAIN)?
- ☐ HAVE YOU EVER HAD DIFFICULTY OPENING OR CLOSING YOUR JAW?
- ☐ DO YOU HAVE FREQUENT HEADACHES?
- ☐ DO YOU CLENCH OR GRIND YOUR TEETH?
- ☐ DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY?
- ☐ HAVE YOU HAD ANY DIFFICULT EXTRACTIONS PREVIOUSLY?
- ☐ HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS?
- ☐ HAVE YOU EVER HAD DIFFICULTY CHEWING?
- ☐ HAVE YOU HAD ANY ORTHODONTIC WORK?
- ☐ HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING/FLOSSING YOUR TEETH?
- ☐ HAVE YOU EVER HAD INSTRUCTIONS ON THE PROPER CARE OF YOUR GUMS?

IS THERE ANYTHING ELSE YOU WOULD LIKE US TO KNOW ABOUT YOUR HISTORY OR REASON FOR YOUR VISIT? IF SO, PLEASE SPECIFY: ______________________________

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

X ______________________________ ______________________________

PATIENT OR PARENT/LEGAL GUARDIAN DATE