COLUMBIA PRIME DENTAL
CONFIDENTIAL

PATIENT INFORMATION

(PLEASE PRINT CLEARLY) SOCIAL SECURITY NUMBER _____-_____-_____

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 SURGICAL OPERATION OR SERIOUS INJURY?	☐	☐
3. ARE YOU TAKING ANY MEDICATION (S) INCLUDING NON-PRESCRIPTION MEDICINE?	☐	☐
4. DO YOU USE TOBACCO?	☐	☐
5. DO YOU USE ALCOHOL?	☐	☐
6. DO YOU USE COCAINE OR OTHER DRUGS?	☐	☐
7. ARE YOU WEARING CONTACT LENSES?	☐	☐

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

_____

_____

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 MEDICATIONS?	☐	☐

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

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

_____

_____

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