Patient Health Information

Name (Last) _____ (First) _____ M.I.___. Patient's Birthday_____

Address _____City, State & Zip _____

Marital Status: C S M O Male__ Female__ Patient's SS# _____

Home Phone# _____ Cell Phone# _____ Work Phone#_____

Your Place of employment_____Occupation_____E-mail_____

Spouse's Name_____ Spouse's Employer _____

Insurance Subscriber Name_____**Date of Birth**_____ **Subscriber SS#** _____

Insured person's place of employment_____ Work Phone#_____

Your Relationship to Insurance Subscriber: Self / Spouse / Child / Other

Dental Insurance Company and Phone #_____**Group #** _____

Person responsible for this account? _____Phone# _____

In Case of Emergency Contact Person: _____ Phone#_____

Has any member of your family ever been treated in our office? _____

To whom may our office thank for referring you to Dr. Jeremy Bold?_____

Insurance Disclaimer

I understand that my insurance is an agreement between me and my insurance company and that I am responsible for my balance regardless of my insurance. I assign dental benefit payments to be paid directly to Dr. Bold from my insurance company.

Patient's (Parent's) Signature_____Date_____

Initial Treatment Consent

I give permission for my dentist and his/her clinical team to take any necessary x-rays, photos, or study models to enable complete diagnosis and treatment.

Patient's (Parent's) Signature_____ Date_____

Dental History

please circle

Do you have a specific dental problem? Describe_____	Yes	No
Do you have routine dental exams? Last Visit_____	Yes	No
Do you think you have active decay or gum disease?_____	Yes	No
Do you brush and floss on a routine basis?_____	Yes	No
Do your gums ever bleed?_____	Yes	No
Is there any part of your smile that you want to improve? _____	Yes	No
Would you like the color of your teeth to be whiter?_____	Yes	No
Are there old fillings or dental work that you don't like?_____	Yes	No
Have you ever been treated for gum (periodontal) disease?_____	Yes	No
Do you ever have trouble with Halitosis (bad breath)?_____	Yes	No
Do you clench or grind your teeth during the day or night?_____	Yes	No
Have you ever had an unpleasant dental experience?_____	Yes	No

What is your chief concern or main goal(s) in getting dental treatment?_____

_____

BOLD SMILES DENTAL

Medical History

Have you ever had any of the following? (check boxes that apply) Today's Date_____

	Yes	No		Yes	No		Yes	No
Heart Problems	☐	☐	Asthma	☐	☐	Stroke	☐	☐
High Blood Pressure	☐	☐	Epilepsy	☐	☐	Ulcer	☐	☐
Low Blood Pressure	☐	☐	Headaches	☐	☐	Venereal Disease	☐	☐
Circulatory Problems	☐	☐	Hepatitis or Jaundice	☐	☐	Hemophilia	☐	☐
Heart Murmurs	☐	☐	Cancer	☐	☐	Nervous Problems	☐	☐
Radiation Treatment	☐	☐	Respiratory Problems	☐	☐	Excessive Bleeding	☐	☐
Artificial heart valve	☐	☐	Psychiatric Care	☐	☐	Tuberculosis	☐	☐
Artificial Joint	☐	☐	Blood Disease	☐	☐	Alcohol Addiction	☐	☐
Anemia	☐	☐	Arthritis	☐	☐	Drug Addiction	☐	☐
Phen/Fen	☐	☐	Thyroid Disorder	☐	☐	Diabetes	☐	☐
Mitral Valve Prolapse	☐	☐	Swollen Neck Glands	☐	☐	Dizziness or Fainting	☐	☐
Heart Surgery	☐	☐	Recent Weight Loss	☐	☐	Kidney Problems	☐	☐
Rheumatic Fever	☐	☐	Sinus Problems	☐	☐	Cortisone Medicine	☐	☐
Heart Pacemaker	☐	☐	A.I.D.S.	☐	☐	HIV Positive	☐	☐

Physician's Name_____ Phone #_____ *Please Circle*

Have you ever been hospitalized or had a major operation? Discuss_____ Yes No

Have you ever had a serious injury to your head or neck? Discuss_____ Yes No

Have you ever responded adversely to medical or dental treatment?_____ Yes No

Do you smoke or chew tobacco? How much?_____ Yes No

Do you have trouble breathing or snoring while sleeping?_____ Yes No

Please list any medications, pills, or drugs that you are taking _____

_____

Please check any medications or substances that you may be allergic to below:

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Other _____

Have you had any significant illness not checked above? Discuss_____

WOMEN (Please Check): ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking Oral Contraceptives ☐ Menopause

Reviewed by Dr._____ Patient's or (Parent) Signature_____

Medical Updates - I have read my MEDICAL HISTORY and confirm that it adequately states past and present conditions.

Date	Changes in Medical History		Patient Signature	Reviewed By
_____	_____	None ☐	_____	_____
_____	_____	None ☐	_____	_____
_____	_____	None ☐	_____	_____
_____	_____	None ☐	_____	_____
_____	_____	None ☐	_____	_____
_____	_____	None ☐	_____	_____
_____	_____	None ☐	_____	_____