PATIENT INFORMATION

Personal Information

Patients Name:_____ Prefers:_____ Birthdate:_____
If patient is a minor, give name of legal guardian:_____ Relationship:_____
Address:_____
Street City ST Zip
Home Phone:_____Cell:_____
Social Security # of patient:_____ Drivers License # of Patient:_____
Email Address:_____ Confirm appts by Email? Yes _ No _
(Please Circle) Single Married Divorced Widowed Minor

Employer:_____ Occupation:_____
Business Address:_____ Bus. Phone:_____

Spouse's Name:_____ Soc Sec. #:_____ DOB:_____
Spouse's Employer:_____Occupation:_____
Business Address:_____ Bus. phone:_____
In case of Emergency whom should we call?:_____ Phone:_____

"Our practice grows by enthusiastic referrals from our dental clients and friends. Whom may we thank for referring you to our office?"

_____

Financial Information

Person responsible for Account:_____ Relationship to Patient:_____
Billing address (if different than patients):_____
Telephone :_____Email address:_____

Primary Dental Insurance

Name of Insurance Company:_____ Name of Insured:_____
DOB of Insured:_____ Soc. Sec. #:_____ Group #:_____

Secondary Dental Insurance

Name of Insurance Company:_____ Name of Insured:_____
DOB of Insured:_____ Soc. Sec. #:_____ Group #:_____

Agreement and Consent:

The undersigned hereby authorizes Dr. Risbrudt to take x-rays, diagnostic casts, photographs, or any other diagnostic aids deemed appropriate by Dr. Risbrudt to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. Risbrudt to perform any and all forms of dental treatment, medications and therapy that may be indicated and further authorize and consent that Dr. Risbrudt choose and employ such assistance as deemed appropriate. I also understand that the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I understand that insurance will be billed as a courtesy and that there are no guarantees of benefits or payments, therefore the balance will be completely mine and disputes with insurance companies will be handled by myself. I further understand that a 1.5% finance charge (18% annually) will be added to any balance over 60 days. In the event of default I (we) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection on this note.

Patient/Parent/Responsible Party_____ Date_____

Medical and Dental History

Dental History

How would you describe your dental health? Excellent Good Fair Poor

Have you ever had orthodontic treatment/braces? Yes No DNK

Are your teeth sensitive to hot or cold? Yes No DNK

Date of your last dental cleaning_____ Date of your last full mouth xray_____

Have you had previous gum trouble? Yes No DNK

Do you use mints, Lifesavers, hard candies, etc…regularly? Yes No DNK

Problems relating to occlusion "bite" or jaw joints:

Are you aware of a tired feeling in your face? Yes No DNK

Do you have ringing or pain in your ears? Yes No DNK

Do you clench or grind your teeth? Yes No DNK

Do you have frequent headaches? Yes No DNK

Do you have pain around your ears, eyes, head or neck? Yes No DNK

General Health

Do you have any type of health problems?_____ Yes No DNK

Do you have any type of heart problems?_____ Yes No DNK

Do you have high blood pressure? Yes No DNK

Do you have shortness of breath after climbing a flight of stairs? Yes No DNK

Do you bleed for more than 30 seconds for a minor cut? Yes No DNK

Are you taking any medications, blood thinners, cortisone, steroids, recreational drugs?

Please list:_____

Have you been hospitalized in the last five years? Yes No DNK

If so, please explain:_____

Do you faint easily? Yes No DNK

Have you taken phen fen or diet prescriptions? Yes No DNK

Have you been under the care of a physician in the last year? Yes No DNK

If other than a routine physical please explain:_____

Have you had a major illness or serious operation in the past five years? If so, please explain:

_____

Have you had rheumatic fever? Yes No DNK

Do you have any type of artificial joint, heart valve, pacemaker? Yes No DNK

Are you allergic to any medications, latex or anesthetic? Please list:

_____

Please estimate the number of cups, glasses, etc. you consume on a daily basis:

Coffee_____ Tea_____ Soft Drinks_____ Alcoholic Beverages/Wine_____

Family History

Have any members of your family (blood relative) had heart disease?	Yes	No	DNK
Have any members of your family had high blood pressure or Diabetes?	Yes	No	DNK
Do any members of your family snore or have sleep apnea?	Yes	No	DNK

Medical History

On a scale of one to ten, with ten being highest, how would you rate your general health?_____

Anemia?	Yes	No	DNK
Mitral Valve Prolapse/Heart Murmur?	Yes	No	DNK
Stomach Ulcers?	Yes	No	DNK
Excessive thirst/hunger over an extended period of time?	Yes	No	DNK
Change in urination frequency?	Yes	No	DNK
Cuts tend to heal slowly?	Yes	No	DNK
Diabetes?	Yes	No	DNK
Thyroid disturbance, do you take thyroid medications?	Yes	No	DNK
Tuberculosis or Emphysema?	Yes	No	DNK
Hepatitis A B C (please circle)	Yes	No	DNK
Kidney/Bladder disease problems?	Yes	No	DNK
Arthritis or Rheumatism?	Yes	No	DNK
Venereal Disease, Herpes, other?	Yes	No	DNK
Epilepsy, convulsions or Seizures?	Yes	No	DNK
Cancer-chemotherapy or radiation therapy?	Yes	No	DNK
Smoke or use tobacco in any form?	Yes	No	DNK
Are you taking any anti-depressants or sleep medication?	Yes	No	DNK
If yes, please list:_____			
Are you taking any blood thinners/anticoagulants?	Yes	No	DNK
If yes, please list:_____			
Do you take antacids regularly?	Yes	No	DNK
Glaucoma?	Yes	No	DNK
Asthma, hay fever, or eczema?	Yes	No	DNK
Liver problems?	Yes	No	DNK
Males only: Prostate problems	Yes	No	DNK
Females only: Are you pregnant?	Yes	No	DNK
Are you taking birth control pills or hormones?	Yes	No	DNK
Are you nursing?	Yes	No	DNK
Esophageal Reflux (GERD)?	Yes	No	DNK
Do you supplement your diet with vitamins?	Yes	No	DNK
If yes, please list:_____			
Do you routinely eat breakfast?	Yes	No	DNK
Do you exercise on a regular basis?	Yes	No	DNK