Aspen Hills Dental

800 South Washington

Afton , WY 83110

307-885-4337

Lower Valley Family Dental

124 Petersen Parkway Suite #3

Thayne, WY 83127

307-883-4337

1 About You

Today's Date:_____/___/_____

Patient Name: _____

What you Prefer to Be Called:_____ ☐Male ☐Female

Birth date:____/___/____ Age:____ SS#: _____

Physical Address:

_____

_____

Home Phone#:(_____) _____

Work Phone#:(_____)_____

Cell Phone#: (_____) _____

E-mail Address:_____

Referred By:_____

Employer:_____ How Long?_____

Employer's Address:_____

_____

Occupation:_____

Status: ☐Minor ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Spouse's Name:_____

Do you have children? ☐Yes ☐No How Many?_____

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Do You Have Dental Insurance? ☐Yes ☐No (If Yes Please provide front office personnel with card so they can photocopy it.)

DO NOT WRITE BELOW THIS LINE!

Office Use Only

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2 Account Information

Person Ultimately Responsible for Account

Name:_____

Relation:_____

Billing Address: _____

_____

SS#:_____-_____-_____ DOB: _____/____/_____

Work Phone#:(____)_____

Payment Method: ☐ Cash ☐ Check

☐**Credit Card (please put card info below)**

Card # _____

___/___ exp 3 digit code from back ____

☐**Care Credit** (Please put card info below)

Card#_____

PLEASE INITIAL

_____I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand that I am solely responsible for any balance not paid by my insurance company.

____I hereby authorize that any unpaid balance that my insurance benefits did not pay to be charged to the credit card, or Care Credit # listed above.

3 In Event of Emergency

Whom should we contact?_____

Relation_____

Phone (____)_____ Cell (____)_____

Who is your Medical Doctor?_____

Medical Doctor's Phone #:(____)_____
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4 Dental Information

Reason for today's visit: ☐Exam ☐Emergency ☐Consultation

Are You in pain? ☐No ☐ Yes How Long?_____

Please indicate ☑ any of the following problems:

☐Discomfort, clicking or popping in jaw. ☐ Lost/Broken Filling(s) ☐ Stained teeth

☐Red, swollen or bleeding gums. ☐ Teeth Grinding ☐ Locking Jaw

☐Sensitive tooth, teeth or gums. ☐ Ringing in Ears ☐ Bad Breath

☐Blisters/Sores in or around the mouth. ☐ Broken/Chipped tooth/teeth

☐Other:_____

Do you require pre-medication? ☐ Yes ☐ No ☐ I don't know

Previous Dentist:_____ Phone (____)_____

Last Dental Exam:_____/____/_____ Last Dental Xray: _____/____/_____

Times a day you brush?_____ Times a week you floss?_____

What type of tooth brush bristles do you use? ☐ Soft ☐ Medium ☐ Hard

5 Medical History

What medications are you taking? ☐Nerve Pills ☐Pain Killers (including aspirin) ☐Muscle relaxers ☐ Stimulants ☐ Blood Thinners ☐Tranquilizers ☐Insulin ☐Meds for Osteoporosis .

Others:_____

Have you ever taken: Bisphosphonates (ex. Aredia/Fosamax) ☐ Yes ☐ No Phen-fen/Redux ☐ Yes ☐ No

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack/Stroke	Y N Thyroid Problems	Y N Cancer/Tumors	Y N Cosmetic Surgery	Y N Heart Surg./ Pacemaker
Y N Kidney Problems	Y N Shingles	Y N Heart Murmur	Y N Liver Problems	Y N Hepatitis A / B / C
Y N Chemotherapy	Y N Rheumatic Fever	Y N Respiratory Problems	Y N HIV+/AIDS/ARC	Y N Asthma
Y N Mitral Valve Prolapse	Y N Sinus Problems	Y N Arthritis/Rheumatism	Y N Difficulty Breathing	Y N Artifical Valves
Y N Artificial Bones/ Joints	Y N Heart Disease	Y N Psychiatric Problems	Y N Emphysema	Y N Leukemia
Y N Congenital Heart Defect	Y N Venereal Disease	Y N Seizures/Epilipsy	Y N Anemia	Y N Chest Pains
Y N Alcohol/Drug Abuse	Y N Frequent Headaches	Y N Scarlet Fever	Y N Tuberculosis TB	Y N Frequent Neck Pain
Y N Bleeding Problems	Y N Nervousness	Y N Jaw Problems TMJ/TMD	Y N Back Problems	Y N Glaucoma
Y N Stomach Problems	Y N Diabetes/Hypoglycemia	Y N High/Low Blood Pressure	Y N Xray or Cobalt Treatment	

Please list any other surgeries or medical conditions you have or ever had:_____

_____

Are you allergic to any of the following? ☐ Latex ☐ Penicillin / Amoxicillin ☐ Tetracycline ☐ Aspirin ☐ Dental Anesthetics

☐ Foods:_____ ☐Others:_____

Do you use tobacco? ☐ Yes ☐No (If Yes) How used?_____ How much?_____ How Long?_____

Please rate your general health from 1-10:_____

For Women: Are you taking Birth Control pills? ☐ No ☐Yes How many children have you had?_____ Are you Pregnant? ☐Yes ☐No

Are you nursing? ☐ Yes ☐ No

- We Invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the Financial Coordinator. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Office Use Only

Updated _____/_____ **Initials**_____

Updated _____/_____ **Initials**_____

Updated _____/_____ **Initials**_____

Updated _____/_____ **Initials**_____

Updated _____/_____ **Initials**_____

Signature_____ Date_____/_____/_____