REDFEARN Family Dental

We are happy to have you join our great family of patients and friends. The benefits of a healthy, beautiful smile are immeasurable, and our goal is to allow you to obtain the healthy teeth and attractive smile you want and deserve. Please complete this form so that we can provide the best care possible for you.
Thank you!

Today's date: _____

ABOUT YOU

Name: _____ o Female o Male

Preferred To Be Called: _____

Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____

Work phone: _____ Ext: _____ Preferred: _____

Birth date: _____/_____/_____ Social security number: _____

E-mail address: _____

Employer: _____

Present position: _____

Marital status: o Single o Married o Widowed o Divorced

Name of spouse: _____

Spouse's birth date: _____/_____/_____ Spouse's SS#: _____

Spouse's employer: _____

Names of children: _____

How do you enjoy spending your free time? _____

EMERGENCY INFORMATION

Person to contact: _____ Relationship: _____

Phone: _____

Address: _____

INSURANCE INFORMATION

Insurance Co.: _____ Group#: _____

Subscriber Name: _____ Relationship: _____

Subscriber ID: _____ Ins Ph #: _____

9567 S. University Blvd., C-1, Highlands Ranch, CO 80126 Phone 303-683-2300 Fax 303-346-8014

DENTAL & MEDICAL HISTORY

Previous dentist's name: _____ When was your last dental visit? _____
Do you have any dental anxieties? o Yes o No If yes, please explain: _____
If you could wave a magic wand, and change anything about the appearance of your smile, what would it be?
_____
Name of personal physician: _____
Address: _____Phone number: _____
Approximate date of last visit: _____Current health condition: o Excellent o Good o Fair o Poor
Have you had any serious health problems in the last five years? o Yes o No
If yes, please explain: _____
(For women) Are your currently pregnant? o Yes o No If yes, how many months?_____
Do you take a vitamin/herbal supplement? o Yes o No
If yes, which: _____
Are you taking any prescription medications? o Yes o No
Please list: (Name of medication) _____
Chew tobacco or smoke? o Yes o No Consume alcohol daily? o Yes o No

Please check if you're allergic to any of the following:

o Local anesthetics	o Sulfa drugs	o Codeine/other narcotics
o Penicillin/other antibiotics	o Aspirin	o Latex sensitivity
o Barbiturates, sedatives, sleeping pills	o Shellfish, iodine or red wine	o Other_____

Do you have, or have you had, any of the following? Please Circle

o AIDS/HIV Positive	o Drug Addiction	o Hepatitis B or C	o Rheumatism
o Alzheimer's Disease	o Easily Winded	o Herpes	o Scarlet Fever
o Anaphylaxis	o Emphysema	o High Blood Pressure	o Shingles
o Arthritis/Gout	o Epilepsy or Seizures	o Hives or Rash	o Sickle Cell Disease
o Artificial Heart Valve	o Excessive Bleeding	o Hypoglycemia	o Sinus Trouble
o Artificial Joint	o Excessive Thirst	o Irregular Heartbeat	o Spina Bifida
o Asthma	o Fainting Spells/Dizziness	o Kidney Problems	o Stomach/Intestinal Disease
o Blood Disease	o Frequent Cough	o Leukemia	o Stroke
o Blood Transfusion	o Frequent Diarrhea	o Liver Disease	o Swelling of Limbs
o Breathing Problem	o Frequent Headaches	o Low Blood Pressure	o Thyroid Disease
o Bruise Easily	o Genital Herpes	o Lung Disease	o Tonsillitis
o Cancer	o Glaucoma	o Mitral Valve Prolapse	o Tuberculosis
o Chemotherapy	o Hay Fever	o Pain in Jaw Joints	o Tumors or Growths
o Chest Pains	o Heart Attack/Failure	o Parathyroid Disease	o Ulcers
o Cold Sores/Fever Blisters	o Heart Murmur	o Psychiatric Care	o Venereal Disease
o Congenital Heart Disorder	o Heart Pace Maker	o Radiation Treatments	o Yellow Jaundice
o Convulsions	o Heart Trouble/Disease	o Recent Weight Loss	o Rheumatism
o Cortisone Medicine	o Hemophilia	o Renal Dialysis	o Scarlet Fever
o Diabetes	o Hepatitis A	o Rheumatic Fever	o Shingles

Have you ever had any serious illness not listed above? If yes, please explain: _____

The information I have given is true and accurate to the best of my knowledge

Signature _____ ***Date*** _____

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