Prairie Dental Associates, P.C.

Date_____

Last Name	First Name	Address	City	State	Zip Code

Home Telephone	Cell Phone	Business Phone	Birth Date	Referred By

Dental Insurance Carrier	Social Security Number	Group Number	Dental Insurance I.D. Number

Medical History

Name and address of Physician_____

My last physical examination was on:_____

I am under medical treatment for:_____

_____

_____

When was your blood pressure last checked? _____ What was it? _____

Do you have or have you had any of the following diseases or medical conditions:

Mitral valve prolapse or heart murmur	Yes	No	Diabetes/low blood sugar	Yes	No
Congenital heart problems	Yes	No	Hepatitis or liver disease	Yes	No
Damaged heart valves	Yes	No	Kidney disease	Yes	No
High blood pressure	Yes	No	Arthritis or rheumatism	Yes	No
Pacemaker	Yes	No	AIDS or lupus	Yes	No
Asthma or breathing problems	Yes	No	Ulcers or digestive problems	Yes	No
Allergies and/or hives	Yes	No	Psychiatric/emotional	Yes	No
Sinus trouble or hay fever	Yes	No	Blood disorders	Yes	No
Epilepsy or seizures/fainting	Yes	No	Any joint replacements	Yes	No

Please check and <u>list</u> any medications you are taking:

			Name of Medication
High blood pressure medication	Yes	No	_____
Heart medication	Yes	No	_____
Blood thinners	Yes	No	_____
Aspirin	Yes	No	_____
Antibiotics	Yes	No	_____
Steroids	Yes	No	_____
Antihistamines or allergy medication	Yes	No	_____
Mood stabilizers or anti-anxiety drugs	Yes	No	_____
Oral Contraceptives	Yes	No	_____
Nutritional supplements	Yes	No	_____
Any drugs/medications not listed			_____

Are you <u>allergic</u> or have you <u>reacted adversely</u> to any of the following:

Penicillin	Yes	No	Latex or rubber	Yes	No
Other antibiotics	Yes	No	Costume or inexpensive jewelry	Yes	No
Codeine or Vicodin	Yes	No	Other _____		
Aspirin	Yes	No			

Women Only

Are you pregnant?_____ Due date:_____

Do you have any problems associated with your menstrual period? Yes No

Are you nursing or planning on nursing? Yes No

Dental History

What is the reason for your visit today? _____

When was your last dental exam?_____Last cleaning?_____Last x-rays_____

Previous dentist?_____ What was done at your last dental visit?_____

What did you like **least** about your last dental office?_____

Do you have any dental problems or concerns right now?_____

Are any of your teeth sensitive to:

Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or chewing?	Yes	No
Brushing?	Yes	No

Have you noticed the following:

Bleeding gums?	Yes	No
Mouth odors?	Yes	No
Loose teeth?	Yes	No
Food trap areas?	Yes	No

Do you:

Clench or grind your teeth?	Yes	No
Breathe through your mouth?	Yes	No
Wake up with tired jaws?	Yes	No
Smoke or chew tobacco?	Yes	No
Have jaw joint popping?	Yes	No

Would you like whiter teeth or a more attractive smile?

Yes No

Do you smoke or use tobacco products of any kind or have you ever done any of the above?

Yes No

Have you ever had:

Orthodontic treatment?	Yes	No
Oral surgery?	Yes	No
Gum treatment?	Yes	No
Gum surgery?	Yes	No
Bruxism/night guard	Yes	No
TMJ appliance/bite guard	Yes	No

Do you get frustrated because you always have new cavities or something has to be repaired on a frequent basis?

Yes No

Do you feel you will eventually have dentures?

Yes No

Do you want to control dental disease and keep your own teeth?

Yes No

Please check any of the following that apply:

I would like my teeth to be whiter.	Yes	No
I do not like my silver/black fillings	Yes	No
I sometimes hide my teeth when I smile.	Yes	No
I have discolored fillings that I don't like.	Yes	No
The color of my teeth is too dark.	Yes	No
I think my teeth are shaped funny.	Yes	No
I have spaces between my teeth I don't like.	Yes	No

Is there anything else about your past dental treatment that you would like us to know?

_____

Authorization, Release & Agreement to Pay for Services Rendered

I authorize Prairie Dental Associates to release any information requested by my insurance carrier, third party payor or health practitioner. I understand my insurance is an agreement between me and my insurance company and that I am ultimately responsible for payment for services rendered by the doctors and staff at Prairie Dental Associates. I understand it is my responsibility to ensure that my dentist has met my insurance carrier's requirements, if any, to render treatment. I authorize payment directly to Prairie Dental Associates. I authorize Prairie Dental Associates to act as my agent to help me obtain payment from my insurance company. This authorization will remain in effect until revoked by me in writing. ***Payment in full (or deductibles and co-payment for patients with dental insurance) is expected at each appointment.*** For your convenience, we offer the following methods of payment: Please check the option which you prefer. ___Cash; ___ Personal Check; ___MasterCard; ___VISA. If you have any questions concerning fees and financial obligations, it will be our pleasure to assist you. Patient or responsible party will be responsible for all collection costs and attorney fees (33% of the balance when turned over to collections). I understand that billing/finance charges will be added to the unpaid balance of my account after 60 days. I hereby acknowledge that I have read and understood Prairie Dental Assoc. Notice of Privacy Practices, have obtained a copy upon request and will receive a copy of any amendments upon request.

Signature of Patient/Responsible Party on Account_____