

Alaska Premier Dental Group

Patient Information

Patient Name: _____ Birth Date: _____
LAST FIRST MI

Male Female Status: Married Single Child

Social Security #: _____ Driver's Lic. #: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Mailing Address: _____
STREET / PO BOX APT. OR UNIT #

CITY STATE ZIP CODE

E-mail Address: _____

Who may we thank for referring you? Family/Friend Name: _____

Location TV Work School Newspaper Radio Phonebook

Responsible Party Information

Name: _____ Birth Date: _____
LAST FIRST MI

Social Security #: _____ Driver's Lic. #: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail Address: _____

Health Information

Have you ever had any of the following? Please check those that apply:

- AIDS/HIV Positive
- Anemia
- Arthritis
- Artificial Joints
- Asthma
- Blood Disease
- Cancer
- Diabetes
- Epilepsy
- Excessive Bleeding
- Fainting/Dizziness
- Glaucoma

- Hay Fever
- Head Injuries
- Heart Disease
- Heart Murmur
- Hepatitis A / B / C
- High Blood Pressure
- Kidney Disease
- Liver Disease
- Mental Disorders
- Nervous Disorders
- Pacemaker
- Radiation Treatment

- Respiratory Problems
- Rheumatic Fever
- Rheumatism
- Stomach Problems
- Sinus Problems
- Stroke
- Tuberculosis
- Tumors
- Ulcers
- Thyroid
- Pregnant now?
Due Date: _____

Allergies:

- Aspirin
- Codeine
- Erythromycin
- Latex
- Local Anesthetic
- Penicillin
- Other: _____

PREMED Y / N (circle one)

■ Have you ever had any complications following dental treatment? Yes No

If yes, please explain: _____

■ Are you now under the care of a physician? Yes No

If yes, please explain: _____

■ Name of Physician: _____

■ Please list any current medications you are taking: _____

■ Is there any other medical or dental information you feel I should know about? Yes No

If yes, please explain: _____

DENTAL HISTORY

Please check any of the following that apply to you:

- Sensitivity (hot, cold, sweet)
Where? _____
- Headaches, neck or jaw joint pain
- Mouth ulcers or cold sores
- Teeth or fillings breaking
- Grinding or clenching teeth
- Bleeding, swollen, irritated gums
- Loose, tipped or shifting teeth
- Bad breath

Do you have or have you had any of the following?

- Dentures
- Partial dentures
- Braces
- Gum treatments

Please share the following dates:

- Your last cleaning _____/_____/____
- Your last oral cancer screening _____/_____/____
- Your last complete x-rays _____/_____/____

Name of Previous Dentist

City _____ **State** _____

Phone Number _____

Why did you leave your previous dentist?

If you could whiten your teeth for a cost you could afford, would you do it? Y N

Is keeping your teeth important to you? Y N

Do you smoke or use chewing tobacco? Y N
How much? _____ For how long? _____

If you could change your smile, would you:

- Whiten your teeth
- Straighten your teeth
- Close spaces
- Replace metal fillings with tooth colored fillings
- Repair chipped teeth
- Replace missing teeth
- Replace old crowns that don't match
- Have a smile makeover

On a scale of 1-10; 10 being the highest

- How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10
- Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

What is the most important thing to you about your future smile and dental health?

What is the most important thing to you about your dental visit today?

DENTAL INSURANCE INFORMATION (Primary)		
Insured's Name	DOB	SS#/ID
Insured's Employer		
Insurance Co		
Insurance Co Address		
Phone #		
Group #		

DENTAL INSURANCE INFORMATION (Secondary)		
Insured's Name	DOB	SS#/ID
Insured's Employer		
Insurance Co		
Insurance Co Address		
Phone #		
Group #		

I have reviewed the above information and give authorization to take x-rays, study models, photographs or any other diagnostic aids to make a thorough diagnosis of needs. I also give authorization to perform agreed treatment, medication and therapy that may be indicated. I also understand that the use of anesthetic agents embodies a certain risk.

I authorize use of any information necessary to process my insurance. I also authorize my insurance company(s) to issue the dental benefits of my plan directly to this office.

X _____ Date: _____
Signature of patient, parent or guardian

X _____ Date: _____
Doctor's Signature