Alaska Premier Dental Group

Patient Information

Patient Name: ____ Birth Date: _____________
Last First MI
Status: Married Single Divorced Separated Widowed
Male Female Social Security #: _______________________ Driverøs Lic. #:_________________
Home Phone:_____________ Work Phone:_______________ Cell Phone: __________________
Address:____
Street Apt. or Unit #
____
City State Zip Code
E-mail Address:____

Emergency Contact Name: ____________________________ Phone___________________
Closest relative not living with you:________________________ Phone:______________________

Who may we thank for referring you? Family/Friend ó Name:_____________________________________
Location TV Work School Newspaper Radio Phonebook Internet Insurance

Spouse/Life Partner Information

Name:____ Birth Date:_______________
Last First MI

Male Female Social Security #:___________________ Driverøs Lic. #:_________________
Home Phone:_____________ Work Phone: __________________ Cell Phone: __________________
Address:____
Street Apt. or Unit #
____
City State Zip Code
Employer: _____________________________ 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
☐ Jaundice
☐ 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
☐ STD
☐ Pregnant now?
Due Date:_________

Allergies:
☐ Aspirin
☐ Codeine
☐ Erythromycin
☐ Latex
☐ Local Anesthetic
☐ Penicillin
☐ Peanuts
☐ Other:
____
____
☐ None of the Above

- 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:____Phone:___________________
- 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? UR, LR, UL, LL How Long? ________
- Headaches, neck or jaw pain ☐
- Mouth ulcers or cold sores ☐
- Teeth or fillings breaking ☐
- Grinding or clenching teeth ☐
- Bleeding, swollen, irritated gums ☐
- Loose, chipped or shifting teeth ☐
- Bad breath

Do you have or have had any of the following?

- Dentures ☐
- Braces (traditional or Invisalign) ☐
- 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**____________

Why did you leave your previous dentist? _________

____

Have you ever wanted to whiten your teeth or to learn more about teeth whitening? **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:

-Straighten your teeth ☐

-Replace metal fillings with tooth colored fillings ☐

-Repair chipped teeth ☐

-Replace missing teeth ☐

-Replace old crowns that donøt match ☐

-Have a smile makeover ☐

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

-How important is your dental health?

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)		
Insuredøs Name	DOB	SS# /ID
Employer		
Insurance Co.		
Phone #		
Group #		

DENTAL INSURANCE INFORMATION (Secondary)		
Insuredøs Name	DOB	SS# /ID
Employer		
Insurance Co.		
Phone #		
Group #		

I have reviewed the above and authorize Doctor to take x-rays, study models, photographs or any other diagnostic aids to make a thorough diagnosis of the patient's needs. I also authorize Doctor administer and 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 my insurance company to issue the dental benefits of my plan directly to this office. I also authorize use of any information necessary to process dental insurance

X ____ Date:______________________________

Signature of patient

X ____ Date:______________________________

Doctorøs Signature

Office Use Only

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