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Welcome to Our Office

We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient Information

Patient Name:_____ Date of Birth:_____ Sex:_____ Age:_____

Home Address:_____ City:_____ State:_____ Zip:_____

Billing Address (if different):_____ City:_____ State:_____ Zip:_____

Home phone:_____ Cell:_____ Email:_____ S.S. #: _____

Employer/ Occupation: _____ Business Phone: _____

Spouse's Name & Phone #:_____ Emergency Phone # (if other than spouse):_____

Dental Insurance:_____ Group #:_____

Subscriber's Name:_____ Relation to Patient:_____ Subscriber #:_____

Insurance Mailing Address:_____Subscriber S.S. #:_____

City_____State_____Zip_____Insurance Phone:_____Employed By:_____

Name of your Physician:_____ Date of last visit to Medical Doctor:_____

Physician Address:_____ Physician Phone #:_____

Name of previous dentist:_____ Date of last visit to dentist:_____

Referred to us by: _____

Dental Health History

	Yes	No
Are you apprehensive about dental treatment? _____	☐	☐
Have you had problems with previous dental treatment?	☐	☐
Do your gums bleed easily? _____	☐	☐
Have you ever noticed slow-healing sores in or about your mouth? _____	☐	☐
Are your teeth sensitive?_____	☐	☐

	Yes	No
Do you clench or grind your jaws frequently?_____	☐	☐
How often do you brush? _____		
How often do you floss? _____		
Do you have earaches or pain in front of the ears? __	☐	☐
Do you have any jaw symptoms or headaches upon awaking in the morning? _____	☐	☐
Do you have temporomandibular jaw disorders (TMD)?	☐	☐

Medical Health History: Do you have, or have you had, any of the following?

	Yes	No
Heart Problems? _____	☐	☐
Chest Pain_____	☐	☐
Shortness of Breath _____	☐	☐
Blood Pressure Problem (High/Low?) _____	☐	☐
Heart Murmur _____	☐	☐
Heart Valve Problem_____	☐	☐
Rheumatic fever _____	☐	☐
Pacemaker _____	☐	☐
Artificial Heart Valve _____	☐	☐
Blood Problems_____	☐	☐
Abnormal Bleeding _____	☐	☐
Blood Disease (Anemia) _____	☐	☐

	Yes	No
Allergy Problems _____	☐	☐
Sinus Problems_____	☐	☐
Skin Rashes _____	☐	☐
Taking Allergy Medication_____	☐	☐
Asthma _____	☐	☐
If yes, do you use an inhaler? _____	☐	☐
Intestinal Problems_____	☐	☐
Ulcers _____	☐	☐
Kidney or Bladder Problems _____	☐	☐
Bone or Joint Problems _____	☐	☐
Arthritis _____	☐	☐
Back or Neck Pain_____	☐	☐

Medical Health History Continued

	Yes	No
Joint Replacement (e.g. total hip, pins, or implants)	☐	☐
Fainting Spells, Seizures, or Epilepsy	☐	☐
Stroke(s)	☐	☐
Frequent or Severe Headaches	☐	☐
Persistent cough or swollen glands	☐	☐
Cancer/Tumor	☐	☐
Diabetes	☐	☐
Tuberculosis or other Respiratory Disease	☐	☐
Do you drink alcohol?	☐	☐
Do you smoke?	☐	☐
If so, how much?		
Hepatitis, jaundice, or liver trouble	☐	☐
HIV-positive/AIDS	☐	☐
Glaucoma	☐	☐
Do you have any disease, condition, or problem not listed previously that you feel we should know about?	☐	☐

If so, please describe: _____

_____

List any Medications you are currently taking:

_____

_____

_____

_____

_____

_____

_____

_____

During the past 12 months, have you taken any of the following?	Yes	No
Anticoagulants (e.g.., Coumadin)	☐	☐
Nitroglycerin	☐	☐
Cortisone (Steroids)	☐	☐

Are you allergic, or have reacted adversely, to any of the following?	Yes	No
Local Anesthetics (“Novocaine”)	☐	☐
Penicillin	☐	☐
Other antibiotics	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐
Aspirin, Acetaminophen, or Ibuprofen	☐	☐
Codeine, Demerol, or other narcotics	☐	☐
Reaction to metals	☐	☐
Latex or Rubber Dams	☐	☐

Women	Yes	No
Are you taking contraceptives or other hormones?	☐	☐
Are you pregnant?	☐	☐
If so, expected delivery date:		
Are you nursing?	☐	☐

Notes: _____

_____

_____

_____

Patient/Parent Signature: _____ Date: _____

Dentist/Hygienist Initial: _____ Date: _____

Update Initial: _____ Date: _____

Authorization / Consent

I affirm that the above information and health history information is complete and correct to the best of my knowledge. I understand that it is my responsibility to inform my doctor if I, and/or my dependent have changes to this information.

I certify that I, and/or my dependent assign all insurance benefits, if any, to Dr. Richard Baudendistel, otherwise payable to me. I understand that I am responsible for payment of services rendered as well as any insurance deductible or co-payment that my insurance does not cover. I authorize Dr. Baudendistel to release any information necessary to secure payment for services rendered.

_____

Signature of Patient / Parent / Guardian Date

The highest compliment our customers can give us is to recommend us to a friend.
We appreciate your referrals!