Patient Information

Date____ Birthdate ____

Name ____

Last First Middle

Address ____

Street City State Zip

Nickname _____________________________________ Email____

Spouse Name __________________________________

Employer______________________________________ Occupation ____

Home Phone _________________________ Cell Phone __________________________ Work Phone ________________________

Please circle number that is best to reach you: Home Cell Work

Emergency Contact ______________________________ Phone ____

Referred by ____

Responsible Party Information

Name ____

Last First Middle

Address ____

Street City State Zip

Home Phone ________________________ Cell Phone ________________________ Work Phone ____

Employer____

Employer Address ____

Street City State Zip

Dental Insurance Information

Insured's Name____

Last First Middle

Insurance Company ____________________________ Group #___________________ ID#____

Insurance Company Address ____

Street City State Zip

Employer ____

Employer Address____

Street City State Zip

Secondary Insurance Information

Insured's Name____

Last First Middle

Insurance Company ____________________________ Group #_________________________ ID#____

Insurance Company Address ____

Street City State Zip

Employer ____

Employer Address____

Street City State Zip

Medical History

Physician____ Date of Last Visit ____

Address ____ Phone Number ________________________
Street City State Zip

Please list any medications, prescriptions, ____

over the counter & supplements you are currently taking. ____

(If you have a list, we can make a copy) ____

____

Do you have any allergies? ____

Have you had any serious illness or operations? ____

Are you pregnant? _____________ Are you nursing? _________________

Circle all that apply

Abnormal bleeding, hemophilia
Anemia
Arthritis
Asthma
Artificial joints, pins, i.e. Hip, knee replacements
Back, Neck problems
Bone disorders
Cancer
Chemical dependency
Chemotherapy
Circulatory problems
Congenital Heart Defect
Cortisone treatment
Cough- persistent, cough up blood
Diabetes

Dizziness
Epilepsy
Fainting
Gastro Intestinal Disorder
Hay fever
Headaches
Heart murmur
Heart problems
Hepatitis
Herpes, cold sore
High blood pressure
HIV/aids
Kidney problems
Liver problems
Mitral Valve Prolapse

Nervous Disorder
Pace maker
Pneumonia
Radiation Treatment
Rheumatic Fever
Scarlet Fever
Shortness of Breath
Skin Rash
Stroke
Swelling feet/ankles
Thyroid Disorder
Tobacco Habit
Tonsillitis
Tuberculosis
Ulcer

Dental History

Former dentist____ Date of Last Visit _______________________
Name City State

Reason for today's visit? ____

What concerns do you have about your teeth? ____

How often do you brush? _______________________________________ How often do you floss? ____________________________________

Circle all that apply

Bad breath
Bleeding gums, teeth
Broken filling/teeth
Jaw clicking or popping

Food impaction between teeth
Grinding teeth
Loose teeth

Periodontal treatment
Sensitivity to temperature
Sensitivity to chewing
Sores in mouth

Mouth breather
Past facial, mouth, teeth injuries
Reaction to local anesthetic

The above information is complete and correct, to the best of my knowledge. If I, or my minor child ever have any health changes. I understand that it is my responsibility to inform my doctor. I certify that if I and/or my dependent(s) have insurance coverage, I assign all insurance benefits directly to Dr. Dutton/ Dr. Koberlein, otherwise payable to me for services rendered. I understand that I am financially responsible to all charges whether or not paid by insurance. I authorize my signature to be used on all insurance submissions. The dentist may disclose my health care information to my insurance company for the purpose of determining insurance benefits and obtaining payment for services.

____ _____________

Signature of Patient, Parent or Guardian Date