Welcome to STONEWOOD DENTAL

Patient Information

☐ Mr. ☐ Ms. ☐ Miss ☐ Mrs. ☐ Dr.

Name _____

Address _____

City/St/Zip _____

Spouse's Name_____

Phone # ( ) _____ SSN# _____

Birth Date ___/____/___ Age __ __ ☐ Male ☐ Female

☐ Single ☐ Married ☐ Widowed

☐ Separated ☐ Divorced ☐ Dependent

Responsible Party

If other than patient

Relationship to Patient _____

Name _____

Address _____

City/St/Zip _____

Spouse's Name_____

Phone # ( ) _____ SSN# _____

Birth Date ___/____/____ Age _____ ☐ Male ☐ Female

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Employment Information

If minor/parent's employment information

Employer _____

Work Phone # ( ) _____

Occupation_____

How long at current job? _____

Insurance

Subscriber's Name _____

Subscriber's Employer _____

Relationship to Patient _____

Subscriber's SS# or Membership # _____

Subscriber's Birth Date ____/_____/_____

POLICY/GROUP NUMBER_____

Insurance Company_____

Address _____

City/St/Zip _____

Phone # ( ) _____

Emergency person we can contact (other than your family home)

Name Work Phone Home Phone

Names of other family members that are patients here:	Who can we thank for referring you to our office?

Dental History

Previous Dentist How long? How often do you have your teeth cleaned?

Last Dental Exam Last Dental X-Ray Last Dental Treatment

What is your immediate dental concern?

PLEASE CHECK IF YOU HAVE, OR EVER HAD THE FOLLOWING:

☐ Unhappy with the appearance of your teeth.
☐ Unfavorable dental experiences.
☐ Dental fears.
☐ Periodontal (gum) treatment: when _____
☐ Unhealed injuries or inflamed areas in or around your mouth.
☐ Growth or sore spots in your mouth.
☐ An unpleasant taste or odor in your mouth.

Assignment & Release

I hereby authorize my insurance benefits to be paid directly to the dentist. I am financially responsible for any balances due and authorize the dentist to release any information required for this claim.

I authorize that my records can be used by the doctor if he so determines.

In consideration of the service rendered to me by this dental office, I am obligated to pay said office in accordance with its credit terms and policy.

I consent to the taking of photographs and x-rays before, during and after treatment, and to the use of same by the doctor in scientific papers or demonstrations.

I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

Signature	Date

Dental Patient Medical History

The answers to the following questions will assist the dentist in evaluating your general health prior to providing your dental treatment.

PLEASE READ CAREFULLY AND ANSWER EACH QUESTION AS ACCURATELY AS POSSIBLE.

1. What is your impression of your present health?

2. Year Last Medical Physical?

3. Circle any of the following which you have had or have at present:

Heart Disease or Condition	Rheumatic Fever	Asthma	Hepatitis	Venereal Disease (syphilis,
Angina Pectoris	Stroke	Hay Fever	Thyroid Disease	gonorrhea, etc)
Frequent Chest Pains	Hemophilia	Emphysema	Glaucoma	Drug Addiction
High Blood Pressure	Bruise Easily	Tuberculosis (TB)	Epilepsy or Seizures	Psychiatric Treatment
Shortness of Breath	Prolonged or Unusual Bleeding	Diabetes	Fainting or Dizzy Spells	Cancer
Swollen Ankles	Anemia	Ulcers	AIDS or AIDS Related Complex	Radiation Therapy
Artificial Heart Valve	Blood Transfusion	Kidney Trouble	HIV Positive	Chemotherapy
Congential Heart Disease	Sickle Cell Anemia	Liver Disease	Cold Sores	Implant Prosthesis
Heart Murmur	Arthritis	Jaundice (other than at birth)	Genital Herpes	Unexplained Weight Loss

4. ARE YOU PRESENTLY, OR HAVE YOU BEEN UNDER THE CARE OF A PHYSICIAN IN THE LAST YEAR? YES ☐ NO ☐
PLEASE LIST:

5. ARE YOU PRESENTLY TAKING ANY MEDICINE OR DRUGS? YES ☐ NO ☐
PLEASE LIST:

6. ARE YOU ALLERGIC TO ANY MEDICINE OR MATERIALS? YES ☐ NO ☐
PLEASE LIST:

7. HAVE YOU EVER HAD A REACTION TO A LOCAL ANESTHETIC? YES ☐ NO ☐

8. HAVE YOU EVER EXPERIENCED ANY COMPLICATIONS FOLLOWING DENTAL TREATMENT? YES ☐ NO ☐

9. DO YOU HAVE ANY ILLNESSES OR DISEASES NOT LISTED ABOVE? YES ☐ NO ☐

10. HAVE YOU EVER BEEN TOLD YOU WERE NOT ABLE TO BE A BLOOD DONOR? YES ☐ NO ☐

11. DO YOU USE TOBACCO? YES ☐ NO ☐
SMOKE: Cigarettes Cigars Pipe SMOKELESS: Chewing Tobacco Snuff or "Dip" Frequency _____

12. ARE YOU PREGNANT? ☐ YES TRIMESTER 1 2 3 ☐ NO TAKING BIRTH CONTROL PILLS? YES ☐ NO ☐

PATIENT COMMENTS
Check if you have added comments on the back of this form

SIGNATURE OF PATIENT *(or legal guardian if patient is a minor)*
X

DATE
X

DENTIST COMMENTS

Blood Pressure	Date	Blood Pressure	Date	Blood Pressure	Date	Blood Pressure	Date	Blood Pressure	Date
Dentist's Signature			Date	Reviewer	Date	Reviewer	Date	Reviewer	Date