WELCOME

Thank you for selecting Creekside Dental, where we strive to provide you with the best possible dental care.

Please fill out this form completely in ink. If you have any questions, we will be happy to assist you.

Patient Information (Confidential)

Today's Date:____/____/___E-mailAddress:_____

Name:_____

Last First MI Mr. Mrs. Ms. Dr.

I prefer to be called:_____ ☐Male ☐ Female

Birthdate:____/____/____Age____SS #_____

Home Address:_____

Apt/Condo #

_____

City State Zip

☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced ☐ Separated

Hm #:(____)_____ Cell/Other #:(____)_____

Wk #:(____)_____Ext:_____DL # _____

Employer:_____

Employer's Address:_____

_____

City State Zip

If Patient is a Student, Name of School/College: _____

_____

College City: _____ College State: _____

Whom may we Thank for referring you?_____

Emergency Contact:_____

Phone #:(_____)_____

Spouse Information

His / Her Name:_____

Wk #:(____)_____ Ext:_____

Person Responsible for Patient:_____

Employer: _____

Wk #:(____)_____Hm # :(___)_____

Billing Address:_____

City:_____ State:_____ Zip: _____

Relation:_____ Date of Birth: ____ / ____ / _____

Drivers License #:_____ State of Issue: _____

Is this person currently a patient in our office? ☐Yes ☐No

Dental Insurance

Primary

Insurance Co. Name:_____

Insurance Co. Address:_____

_____

City State Zip

Insurance Co. Phone #:(____)_____

Group # (Plan, Local or Policy #):_____

Insured's Name:_____Relation:_____

Insured's Birthdate:____/____/____Insured's SS#_____

Insured's Employer:_____

Employer Address: _____

Date Employed: _____/ _____/_____

Deductible Amount: _____

Amount Already Used: _____ Max Benefits: _____

Secondary

Insurance Co. Name:_____

Insurance Co. Address:_____

_____

City State Zip

Insurance Co. Phone #:(____)_____

Group # (Plan, Local or Policy #):_____

Insured's Name:_____Relation:_____

Insured's Birthdate:____/____/____Insured's SS#_____

Insured's Employer:_____

Employer Address :_____

Date Employed:_____/ _____/ _____/

Deductible Amount: _____

Amount Already Used: _____ Max Benefits: _____

Medical History

Do you have a personal physician? ☐Yes ☐No

Physician's Name:_____

Phone #:(____)_____Date of last visit:____ / ____ / _____

Medical History (cont)

Are you under medical treatment now? ☐Yes ☐No
Have you ever been hospitalized for any surgical operation or serious illness? ☐Yes ☐No
Are you taking any prescription / over-the-counter drugs? ☐Yes ☐No
Please list each one:_____
Do you use tobacco of any kind? ☐Yes ☐No
If so would you like to quit? ☐Yes ☐No
Do you use alcohol, cocaine, or other drugs? ☐Yes ☐No
Do you wear contact lenses? ☐Yes ☐No
For Women: Are you taking birth control pills? ☐Yes ☐No
Are you pregnant, or think you may be? ☐Yes ☐No
Week #:_____
Are you nursing? ☐Yes ☐No

Have you ever had any of the following diseases or medical problems

Y N AIDS of HIV Infection
Y N Asthma
Y N Chest Pains
Y N Diabetes
Y N Easily Winded
Y N Epilepsy
Y N Fainting Seizures
Y N Glaucoma
Y N Hay Fever / Allergies
Y N Heart Attack
Y N Heart Trouble
Y N Herpes
Y N High Blood Pressure
Y N Kidney Diseases
Y N Leukemia
Y N Low Blood Pressure
Y N Liver disease
Y N Radiation Therapy
Y N Recent Weight Loss
Y N Respiratory Problems
Y N Rheumatic Fever
Y N Stroke
Y N Swollen Ankles
Y N Thyroid Problems
Y N Tuberculosis (TB)

Please list any other serious medical condition(s) that you have ever had:_____
_____

Medical History (cont)

Are you allergic to any of the following?

Y N Aspirin Y N Sulfa Drugs Y N Penicillin or other antibiotics
Y N Codeine Y N Jewelry/Metals Y N Barbiturates
Y N Local Anesthetics (eg. Novocain) Y N Latex Y N Iodine
Y N Sedatives Y N Other
Please list any other drugs/materials that you are allergic to:_____
_____

Dental History

Date of last Dental Visit: _____/ _____ / _____
What was done? _____
Do your gums bleed while brushing of flossing? ☐Yes ☐No
Are your teeth sensitive to hot or cold liquids or foods? ☐Yes ☐No
Are your teeth sensitive to sweet or sour liquids or foods? ☐Yes ☐No
Do you feel pain in any of your teeth? ☐Yes ☐No
Do you have any sores or lumps near your mouth? ☐Yes ☐No
Have you ever experienced any of the following: ☐Yes ☐No
- Clicking? ☐Yes ☐No
- Pain (joint, ear, side of face)? ☐Yes ☐No
- Difficulty opening, closing, or chewing? ☐Yes ☐No

Do you:
- Have frequent headaches? ☐Yes ☐No
- Clench or grind your teeth? ☐Yes ☐No
- Bite your lips or cheeks? ☐Yes ☐No

Have you ever:
- Had any difficult extractions? ☐Yes ☐No
- Had any prolonged bleeding following an extraction? ☐Yes ☐No
- Had any orthodontic work? ☐Yes ☐No

Thank you for filling out this form completely.

I certify that I have read, understand, and answered the above information to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such Dental Care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

_____
Signature or patient or parent if minor Date

OFFICE USE ONLY OFFICE USE ONLY **OFFICE USE ONLY** OFFICE USE ONLY **OFFICE USE ONLY**

Doctor's Comments:_____
_____
_____

Signature: _____ **Date:**_____