Patient Information

Patient Name:____Date:______________
Last, First MI (Preferred Name)

☐ Male ☐ Female ☐ single ☐ married ☐ child ☐ other

Birth Date ______/______/______ Social Security# if over 18__________________

Phone (Cell):__________________ (Work)__________________ Ext:_____ (Home)________________

Mailing Address:____
Street Apartment #

____
City State Zip Code

Email Address:____

Parent/Guardian if under 18 ____________________________________

Who referred you to our office? ____

HEALTH & MEDICAL HISTORY

Have you ever had any of the following? Please check those that apply:

- ☐ Heart Attack_______
- ☐ Heart Murmur
- ☐ Mitral Valve Prolapse
- ☐ Heart Surgery______
- ☐ Artificial Heart Valve
- ☐ Pacemaker
- ☐ Stent
- ☐ Artificial Joints
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Kidney Transplant
- ☐ Immunosuppressant drugs
- ☐ Immune Deficiencies
- ☐ HIV/AIDS
- ☐ Rheumatism/Arthritis
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Glaucoma
- ☐ Tuberculosis
- ☐ Cancer_____________

- ☐ Radiation
- ☐ Chemotherapy
- ☐ Surgery___________
- ☐ Excessive Bleeding
- ☐ Blood Thinners
- ☐ Hemophilia
- ☐ Liver Disease
- ☐ Hepatitis
  - ☐ Hep A/B
  - ☐ Hep C
- ☐ Anemia
- ☐ Hyperthyroid
- ☐ Low Thyroid
- ☐ Emphysema
- ☐ Asthma
- ☐ Sinus Problems
- ☐ Seizures/Epilepsy
- ☐ Depression
- ☐ Anxiety
- ☐ Intestinal Disorders

- ☐ GERD
- ☐ Reflux
- ☐ Ulcers
- ☐ Defibrillator
- ☐ Alzheimer's
- ☐ Parkinson's
- ☐ Venereal Disease
- ☐ Fainting
- ☐ Pregnancy –Currently DUE DATE__________
- ☐ OTHER MEDICAL CONDITIONS: ________________________

ALLERGIES

- ☐ Ceclor or Cipro
- ☐ Penicillin
- ☐ Clindamycin
- ☐ Erythromycin
- ☐ Sulfa
- ☐ Tetracycline
- ☐ Codeine
- ☐ Hydrocodone
- ☐ Aspirin
- ☐ Ibuprofen
- ☐ Anesthetic type____________

OTHER ALLERGIES

- ☐ Latex
- ☐ Adhesives
- ☐ Acrylics
- ☐ Food Allergies
- ☐ Other____________

Please list all the medications/drugs that you are currently taking:

_____________________. _____________________. _____________________.

_____________________. _____________________. _____________________.

Have you been told by a physician that you need to premedicate for dental procedures? ☐ Yes ☐ No

Are you now under the care of a physician or had recent hospitalization (12 Months)? ☐ Yes ☐ No

If yes, please explain____

Name of Physician:_______________________________________Phone:____________________

DENTAL HISTORY

Primary Reason for Appointment:
☐ Comprehensive Exam ☐Cosmetic Dentistry/Esthetic Consultation ☐Orthodontic ☐Emergency
☐Cleaning

Do you have a specific dental problem you would like addressed?
☐Yes, Please Describe: ____
☐No

When was your last check up and cleaning ________/________/_________

Are your teeth sensitive to: ☐Cold ☐Hot ☐Sweet ☐ Biting/Chewing ☐ Touch

Do your gums bleed? ☐Yes ☐No
Do you clench or grind your teeth? ☐Yes ☐No
Have you noticed cracks in your teeth? ☐Yes ☐No
Do you have clicking or popping in the jaw joint? ☐Yes ☐No
Do you have discomfort in the jaw joint? ☐Yes ☐No
Do you have any sores, ulcers, or growths in your mouth? ☐Yes ☐No
Have you ever had: ☐Scaling and Root Planing ☐ TMJ therapy/surgery
☐Braces ☐Gum Surgery

Do you smoke or chew tobacco products? ☐Yes ☐No
Do you consume alcoholic beverages? ☐Yes ☐No

Are you pleased with the appearance of your teeth? ☐Yes ☐No, Please describe__________________________
Are you interested in improving your smile? ☐Yes ☐No
Would you like whiter teeth? ☐Yes ☐No

Do you have any emotional concerns about dental care? ☐Yes ☐No, Please describe__________________________

Are you interested in some type of sedation? ☐Yes ☐No
If yes: ☐ Nitrous sedation ☐Oral conscious sedation

To the best of my knowledge, all information provided is true and correct. I understand that I need to inform this office of any changes to my health. I consent to dental treatment by Dr. Ferguson or Nielson and their staff as deemed necessary and appropriate.

____ Date:____________________________
Signature of patient, parent or guardian

DENTAL INSURANCE INFORMATION

(Must be completed for our office to accept your dental insurance)

Employee's Name:____ Birthdate:_____/_____/________

Employer Name:______________________________ Member's ID# /Social Security # ____________________

Insurance Co. Name:____ Phone:____________________________________

Insurance Co. Address:____

City:______________________________State:______________________________ZIP:_____________________________

Group #_______________________________ Relationship to Policy Holder (Self, Spouse, Child)______________________

MEDICAL INSURANCE INFORMATION

(Must be completed for our office to accept your medical insurance)

Employee's Name:____ Birthdate:_____/_____/________

Employer Name:______________________________ Member's ID# /Social Security # ____________________

Insurance Co. Name:____ Phone:____________________________________

Insurance Co. Address:____

City:______________________________State:______________________________ZIP:_____________________________

Group #_______________________________ Relationship to Policy Holder (Self, Spouse, Child)______________________

Insurance is a contract between you and your insurance company. We are NOT a party to this contract. We may file claims as a courtesy to our patients. **It is your responsibility to know and understand your policy as well as your benefits.** We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, ect., other than to supply factual information. If your insurance company has not paid the full balance within 45 days, the responsibility for full payment will be yours. Your signature below gives us permission to file to both your medical and/or dental insurance.

Patient's (parent's) Signature ____ Date ____________________________________

MISSED APPOINTMENTS

Valuable appointment time is reserved exclusively for you. We strive to complete our treatment objectives during your reserved time. To better serve all patients, if you must cancel an appointment; please give us at least a 24-hour notice. **Our policy is to charge $25 PER HOUR for missed appointments without a 24-hour notice.**

This is to certify that I, undersigned, understand and agree to abide by this policy.

Patient's (parent's) Signature ______________________________ **Date** ______________________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, ______________________________, have received a copy of this office's Notice of Privacy Practices.

____
Signature

____
Date

Can release information to family members: YES___ NO___

If yes, please list names______________________________

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify)

____

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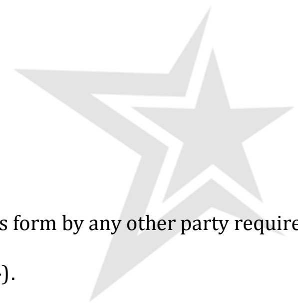

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