Freedom DENTAL

Patient Information

Name _____
LAST FIRST MIDDLE INITIAL NICKNAME

Address _____
STREET Apt #

_____
CITY STATE ZIP

Phone: Home (_____) _____ Spouse's Name _____

Work (_____) _____ How did you hear about us? _____

Mobile(_____) _____ Have you seen our website? _____

E-Mail _____ Emergency Name _____

Employer _____ Emergency Phone (_____) _____

DOB _____ Social Security #_____

Responsible Party Information (if ***not*** the patient, please complete)

Parent or Spouse Name (circle one) _____
LAST FIRST MIDDLE INITIAL

Address _____
STREET Apt #

_____
CITY STATE ZIP

Phone: Home (_____) _____ E-Mail _____

Work (_____) _____ Employer _____

Mobile (_____) _____

DOB _____ Social Security #_____

Dental Information

How long since your last dental visit?_____ Cleaning?_____ X-rays? _____

What is the reason for today's visit? _____

Have you had periodontal (gum) treatment?_____ Orthodontic Treatment?_____ TMJ Treatment? _____

Does anyone in your family have gum/tooth problems? _____

Do you have dry mouth?_____ If yes, when is it worse? Morning Day Night

- ❑ Do your gums bleed?
- ❑ Are your teeth sensitive to hot, cold or sweets?
- ❑ Do you get food wedged between your teeth?
- ❑ Do you have any bumps or swellings in your mouth?
- ❑ Do you have an unpleasant taste in your mouth?
- ❑ Have you had an unfavorable dental experience?

If yes, please explain: _____

The following questions relate to headaches caused by the way your teeth come together and the position of your joint. Please check all that are applicable:

- ❑ Clicking or popping sound in jaw
- ❑ Wake up with headaches
- ❑ Drifting or loose teeth
- ❑ Clenching or grinding teeth
- ❑ Headaches anytime during day
- ❑ Ringing, pain or stuffiness in ear

Please turn over

Medical History and Information

Physician's Name?_____ Phone #?_____ Date of last visit? _____

Do you have or have you ever had?

- ❑ Arthritis
- ❑ Asthma
- ❑ Auto-immune Disorders
- ❑ Blood Transfusion
- ❑ Cancer
- ❑ Cortisone/ Steroid Therapy
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Excessive Bleeding When Cut
- ❑ Glaucoma
- ❑ Heart Murmur
- ❑ Heart Problems
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ HIV Positive
- ❑ Jaundice
- ❑ Kidney Problems
- ❑ Mitral Valve Prolapse
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Rheumatic Fever
- ❑ Stroke
- ❑ Tuberculosis
- ❑ Other _____

Are you allergic to?

- ❑ Aspirin
- ❑ Codeine
- ❑ Penicillin
- ❑ Latex
- ❑ Local Anesthetics
- ❑ Sedatives
- ❑ Other _____

Are you currently under the care of a physician?

❑ Yes ❑ No

Please explain: _____

What medications are you currently taking? _____

Are you taking Aspirin or any other blood thinners (Warfarin, Coumadin, etc.)? _____

Female Patients: Are you pregnant?

❑ Yes ❑ No

Do you take birth control pills? _____

❑ Do you take Vitamins or Supplements? _____

Insurance

Primary Carrier

Subscriber Name_____ Social Security #_____ DOB _____

Employer_____ Insurance Co. _____

Insurance Co. Phone #_____ Group # _____

Relation to patient_____ Do you have any other insurance coverage? _____

Insurance Authorization Statement

I understand that I am responsible for all costs and dental treatment. I hereby authorize Freedom Dental, PLLC to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

Signature_____ Date _____

Treatment Authorization

Before treatment is rendered, adequate radiographs of the teeth and mouth must be taken. I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition.

Payment for all treatment and services rendered are my responsibility.

_____ _____

PATIENT'S SIGNATURE /LEGAL GUARDIAN DATE