Blue Stone Hills
DENTISTRY

Your family's best interest is our only interest!

Patient Information (all information given is confidential)

Today's Date _____

Patient's Name _____ Home Phone Number (_____) _____-_____

Patient's Gender_____ Social Security Number _____

Birth date _____ Address _____

City _____ State _____ Zip Code _____

Email _____

Cell Phone Number (_____) _____- _____

For receiving appointment reminders, you prefer to be contacted by (check which applies best)

☐ Home Phone Call ☐ Cell Phone Call ☐ Text Reminder ☐ Email Reminder

Responsible Party

Name of Person Responsible for this Account _____

Relationship to Patient _____ Address _____

City _____ State _____ Zip Code _____

Home Phone Number (_____) _____-_____ Cell Phone Number (_____) _____-_____

Email Address _____

Social Security Number _____ Driver's License Number _____

Employer _____ Work Phone Number (_____) _____-_____

Email _____

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

If yes, please give relationship and contact information:

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full is expected at the end of each appointment.

☐ Cash ☐ Personal Check ☐ Credit Debit Card(Visa/Mastercard/Discover/AE)

Insurance Information

Named of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security Number _____

Name of Employer _____ Date of Employment _____

Union or Local Number (if any) _____ Work Phone Number _____

Address of Employer _____ City _____

State _____ Zip Code _____

Insurance Company _____ Group # _____ Policy ID # _____

Insurance Co. Address _____ City _____ State _____

Zip Code _____

Patient Medical History

Although dental personnel primarily treat the area in and around the mouth, your child's mouth is part of their entire body. Health problems that your child may have, or medications that he/she may be taking, could have an important interrelationship with the dentistry they receive. Thank you for answering the following questions.

Physician _____ Office Phone (_____) _____-_____
Date of Last Exam _____

Are you currently under a physician's care? ☐ Y ☐ N

If yes, please explain:

_____

_____

Have you ever been hospitalized for any surgical operation or serious illness in the last 5 years?

☐ Y ☐ N

If yes, please explain:

_____

_____

Please list all current medications.

_____

_____

_____

_____

_____

_____

Have you ever been told you need to premedicate prior to dental care? ☐Y ☐N

Does you have any known allergies? ☐ Y ☐ N

If so please list: _____

_____

Are you on a special diet? ☐ Y ☐ N

Do you have or have ever had any of the following?

	Yes	**No**		**Yes**	**No**
AIDS/HIV	□	□	Blood Transfusion	□	□
Alzheimer's Disease	□	□	Breathing Problems	□	□
Anaphylaxis	□	□	Bruise Easily	□	□
Anemia	□	□	Cancer	□	□
Angina	□	□	Chemotherapy	□	□
Artificial Heart Valve	□	□	Low Blood Pressure	□	□
Artificial Joint	□	□	Lung Disease	□	□
Asthma	□	□	Mitral Valve Prolapse	□	□
Blood Disease	□	□	Pain in Jaw Joints	□	□
Cortisone Therapy	□	□	Parathyroid Disease	□	□
Diabetes	□	□	Psychiatric Care	□	□
Drug Addiction	□	□	Radiation Treatments	□	□
Easily Winded	□	□	Recent Weight Loss	□	□
Emphysema	□	□	Renal Dialysis	□	□
Epilepsy or Seizures	□	□	Rheuamtic Fever	□	□

Excessive Bleeding	□	□	Rheumatism	□	□
Excessive Thirst	□	□	Scarlet Fever	□	□
Fainting Spells/Dizziness	□	□	Shingles	□	□
Frequent Cough	□	□	Sickle Cell Disease	□	□
Frequent Diarrhea	□	□	Sinus Trouble	□	□
Frequent Headaches	□	□	Spina Bifida	□	□
Genital Herpes	□	□	Stomach/Intestinal Disease	□	□
Glaucoma	□	□	Stroke	□	□
Hay Fever	□	□	Swelling of Limbs	□	□
Heart Attack/Failure	□	□	Thyroid Disease	□	□
Heart Murmur	□	□	Tonsilitis	□	□
Heart Pace Maker	□	□	Tuberculosis	□	□
Heart Trouble/Disease	□	□	Tumors or Growths	□	□
Hemophilia	□	□	Ulcers	□	□
Hepatitis A	□	□	Venereal Disease	□	□
Hepatitis B or C	□	□	Yellow Jaundice	□	□
High Blood Pressure	□	□			
Hives or Rash	□	□			
Hypoglycemia	□	□			
Irregular Heartbeat	□	□			
Kidney Problems	□	□			
Leukemia	□	□			

Patient Dental History

How often do you brush your teeth? _____

How often do you floss? _____

Date of last dental check-up _____

Previous dentist _____

Do you have any concerns for your teeth? □ Yes □ No

If so, please explain: _____

_____

	Y	**N**
Do your gums bleed while brushing or flossing?	☐	☐
Are your teeth sensitive to hot or cold foods?	☐	☐

Do you have any pain in any of your teeth?	☐	☐
Do you have any lumps or sores near your mouth?	☐	☐
Have you ever had any head, neck, or jaw injuries?	☐	☐
Have you ever experienced jaw pain or clicking or popping?	☐	☐
Do you clench or grind your teeth?	☐	☐
Have you ever had any difficult extractions in the past?	☐	☐
Have you had a history of prolonged bleeding after extractions?	☐	☐
Have you ever had any orthodontic treatment (braces)?	☐	☐
Do you wear dentures/partial dentures?	☐	☐
Date of fabrication? _____		
Have you received oral care instructions for your teeth and gums?	☐	☐
Do you like your smile?	☐	☐

If not, what would you change?

_____

_____

_____

_____

Authorization and Release

Payment is due in full at the time of treatment unless prior arrangements have been approved.

This office participates out-of-network with insurance, and I understanding I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to this dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered to my insurance company.

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in strictest confidence and it is my responsibility to inform the office of any changes to my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

X_____

Signature of patient (or parent/guardian if minor)