WELCOME

Patient Information

Date_____

Patient Name _____
Last Name Middle Initial
_____
First Name

Sex ☐ M ☐ F

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered

Date of Birth: _____

SS#: _____

Address_____

City _____

State _____ Zip_____

E-mail _____

Home (____)_____

Work (____)_____Ext._____

Cell Phone (____)_____

Best time and place to reach you_____

Occupation_____

Patient Employer/School_____

Employer/School Phone (____)_____

Spouse (Parent/Guardian) Name_____

Spouse's Work (____)_____

Birthdate_____ SS#_____

Dental Insurance

Who is responsible for this account?_____

Is patient covered by additional insurance? ☐ Yes ☐ No

Primary Insurance:

Subscriber's Name_____

Date Of Birth_____ SS/Patient ID#:_____

Relationship to Patient_____

Employer_____

Insurance Co. _____

Insurance Phone(____)_____

Group #_____

Secondary Insurance:

Subscriber's Name_____

Date Of Birth_____ SS/Patient ID#: _____

Relationship to Patient_____

Employer_____

Insurance Co._____

Insurance Phone(____)_____

Group #_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____and assign directly to Canyon Vista Dental Care all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dental office, Canyon Vista Dental Care, may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits of the benefits payable for related services.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Relationship to Patient Date

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name_____

Relationship_____

Home Phone (____)_____

Work Phone (____)_____

Health History

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Are you currently taking prescription bisphosphonates, (Fosomax, Zometa, Aredia, Pamisol, etc.) for increased bone density? ☐ Y ☐ N

Pre-med	☐ Y	☐ N	Heart Murmur	☐ Y	☐ N	Respiratory Problems	☐ Y	☐ N
AIDS/HIV	☐ Y	☐ N	Heart Problems	☐ Y	☐ N	Rheumatic Fever	☐ Y	☐ N
Allergies _____			Hepatitis Type_____	☐ Y	☐ N	Rheumatism	☐ Y	☐ N
_____	☐ Y	☐ N	Herpes	☐ Y	☐ N	Sinus Problems	☐ Y	☐ N
Artificial Joints	☐ Y	☐ N	High Blood Pressure	☐ Y	☐ N	Stints	☐ Y	☐ N
Asthma	☐ Y	☐ N	Kidney Disease	☐ Y	☐ N	Stomach Problems	☐ Y	☐ N
Blood Thinner	☐ Y	☐ N	Latex Allergy	☐ Y	☐ N	Stroke	☐ Y	☐ N
Cancer	☐ Y	☐ N	Liver Disease	☐ Y	☐ N	Thyroid Problems	☐ Y	☐ N
Diabetes	☐ Y	☐ N	Low Blood Pressure	☐ Y	☐ N	Tuberculosis	☐ Y	☐ N
Emphysema	☐ Y	☐ N	Mental Disorders	☐ Y	☐ N	Tumor or growths	☐ Y	☐ N
Epilepsy	☐ Y	☐ N	Mitral Valve Prolapse	☐ Y	☐ N	Prosthetics	☐ Y	☐ N
Glaucoma	☐ Y	☐ N	Nervous Disorders	☐ Y	☐ N	Tobacco use_____	☐ Y	☐ N
Heart Disease	☐ Y	☐ N	Pacemaker	☐ Y	☐ N	For how long?_____		
			Radiation Treatment	☐ Y	☐ N			

Please Explain any of the above: _____

Health History continued

Women:

Are you pregnant? ☐ Y ☐ N Due date_____ Are you nursing? ☐ Y ☐ N

Taking birth control pills? ☐ Y ☐ N Hormone Replacement? ☐ Y ☐ N

Please list any current medications: ☐ Please check if you have a list (we will be happy to make a copy for our records).

Medication:	Ailment medication is for:
_____	_____
_____	_____
_____	_____
_____	_____

Have you been admitted to a hospital or received emergency care in the last two years? ☐ Y ☐ N

If yes, please explain: _____

Name of primary care physician:_____ Date of last examination:_____

Phone (____)_____

Are you currently under treatment? If yes, please explain: _____

Please list any other medical conditions not listed above: _____

Dental History

Reason for today's visit_____

_____

Former Dentist_____

Phone (____)_____

City/State_____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Y	☐ N	Burning sensation on tongue	☐ Y	☐ N	Lip or cheek biting	☐ Y	☐ N
Bleeding gums	☐ Y	☐ N	Chew on one side of mouth	☐ Y	☐ N	Loose teeth	☐ Y	☐ N
Blisters on lips or mouth	☐ Y	☐ N	Cigarette, pipe, or cigar smoking	☐ Y	☐ N	Mouth breathing	☐ Y	☐ N
						Mouth pain, brushing	☐ Y	☐ N
			Clicking or popping jaw	☐ Y	☐ N	Orthodontic treatment	☐ Y	☐ N
			Dry mouth	☐ Y	☐ N	Pain around ear	☐ Y	☐ N
			Fingernail biting	☐ Y	☐ N	Periodontal treatment	☐ Y	☐ N
			Food collection between the teeth	☐ Y	☐ N	Sensitivity to cold	☐ Y	☐ N
						Sensitivity to heat	☐ Y	☐ N
			Foreign objects	☐ Y	☐ N	Sensitivity to sweets	☐ Y	☐ N
			Grinding teeth	☐ Y	☐ N	Sensitivity when biting	☐ Y	☐ N
			Gums swollen or tender	☐ Y	☐ N	Sores or growths in your mouth	☐ Y	☐ N
			Jaw pain or tiredness	☐ Y	☐ N			

Referral who may we thank for referring you?

Insurance Company	☐	Yellow Page Ad	☐	Sign/Billboard	☐
Patient:_____	☐	Physician:_____	☐	Internet	☐
Walk-in	☐	Postcard or Mail Piece	☐	Other:_____	☐