ADULT
CONFIDENTIAL PATIENT INFORMATION

ROBERT J. HELLIGE, D.D.S.
ROY H. REINARMAN, D.M.D.

Personal Information

Date_______________

Name:_______________ Preferred Name:_______________ Date of Birth_______________

Address:_______________
(If P.O. Box, please include street address) Street City State Zip

Telephone: Home:_______________ Business:_______________ Cell:_______________

Employer:_______________ SS #_______________ Email_______________

Name of Spouse:_______________ Name of Children:_______________

Referred by:_______________, we would like to thank them. ❑ Family ❑ Co-Worker
❑ Neighbor ❑ Insurance ❑ Phone Book ❑ Newspaper ❑ Welcome Wagon ❑ Other_______________

Person Responsible for Account (if other than patient)

Name:_______________ Relationship:_______________ S.S. #_______________

Address:_______________
Street City State Zip

Telephone: Home:_______________ Business:_______________ Cell:_______________

I will be responsible for payment of the services furnished and agree to pay for such treatment regardless of insurance or any other third party involvement. I also agree, if the need arises for my account to be referred to collection, to pay all agency fees, court costs, attorney's and legal fees.

Signature _______________ Date_______________

Dental Insurance Information

Primary Insurance Co.:_______________

Employee:_______________ Relationship:_______________ S.S. #_______________

Employer:_______________ Policy Number_______________

Employee's Date of Birth:_______________

Secondary Insurance Co.:_______________

Employee:_______________ Relationship:_______________ S.S. #_______________

Employer:_______________ Policy Number_______________

Employee's Date of Birth:_______________

(over)

Dental and Oral Health Information

Please describe any specific dental problem or discomfort you are having at this time: ____________________________

____ How long has it been present? _____________________

If you have had any of the following dental care, please list the dentists and approximate dates:

Periodontal (gum) treatment or surgery: ____

"Braces" or any type of orthodontic treatment: ____

Dental Implants: ____

Any other type of oral surgery: ____

Do you have / have you had / have you noticed any of the following signs or symptoms in your head, neck or mouth?
(Please check Yes or No or each question)

	Yes	No
Teeth that are sensitive to: Hot, cold, sweets, or biting pressure	____	____
An unpleasant taste or persistent bad breath	____	____
Does food catch between your teeth	____	____
Do your gums bleed when brushing	____	____
Red, swollen, tender, bleeding or sore gums	____	____
Gums that have pulled away from the teeth	____	____
Pus between the teeth and gums	____	____
Avoid any area when brushing or chewing	____	____
You clench or grind your teeth	____	____
A clicking, snapping or difficulty when chewing	____	____
Difficulty opening or moving the jaws	____	____
Difficulty speaking or changes in your voice	____	____
Difficulty moving your tongue or "tongue tied"	____	____
Loose or separating teeth	____	____
Changes in the way your teeth fit together	____	____
A color change of the tissues in your mouth	____	____
Pain, tenderness, numbness, or earaches	____	____
Any lumps, swelling or swollen glands	____	____
Sores, ulcers, or rough spots in your mouth	____	____

Your Dental Health:

How do you rate your overall dental health? ❑ Good ❑ Fair ❑ Poor

How many times a day do you brush your teeth? _____

How many times a week do you floss your teeth?_____

Do you use any of the following? (Please check Yes or No for each question)

	Yes	No
Mechanical (electric) toothbrush If Yes, what type or brand? ________________________	____	____
Flossing aids (floss holders, threaders, etc.)	____	____
Oral irrigating device (Waterpik)	____	____
Fluoride treatments or supplements at home. If Yes, which ones: ________________________	____	____
Mouthwashes or oral rinses. If Yes, what brand? ________________________	____	____

	Yes	No
Do you have any missing teeth that have not been replaced?	____	____
Why have you not had them replaced? ________________________________		
Do you wear any removable dental appliances?	____	____
If Yes, what type and for how long? ________________________________		
Have you ever had your teeth whitened or bleached?	____	____
Would you like to have your teeth whitened or bleached?	____	____

How do you feel about the appearance of your smile and what would you change if you could?

____

	Yes	No
Are you frustrated because you always need something treated or repaired when you visit a dentist?	____	____
Do you feel you will eventually wear artificial dentures?	____	____
Have you ever had any complications from an extraction or dental treatment?	____	____
If Yes, please explain ________________________________		
Have you ever had any other dental conditions, major trauma or injury to your head, neck or mouth?	____	____
If Yes, please explain ________________________________		

If you are a new patient to this practice:

Date of last dental visit _________________ Dentist's Name________________________ City & State________________________

Health Information and History

Today's Date: ____________________

Patient's Name: ____________________ Date of Birth: ____________________

If you are completing this form for another person:

Your name: ____________________ Phone: ____________________ Relationship: ____________________

Emergency Contact: (If not listed below)

Name: ____________________ Phone: ____________________ Relationship: ____________________

Primary Physician: ____________________ Phone: ____________________ City & State: ____________________

Date of last physical examination: ____________________ Date of last blood test/work up: ____________________

Other Physicians & Specialists:

Name: ____________________ Specialty: ____________________ Phone: ____________________ City & State: ____________________

Name: ____________________ Specialty: ____________________ Phone: ____________________ City & State: ____________________

1. Within the last 3 years, have you been hospitalized or had surgery? ❑ Yes ❑ No

   If Yes, please give reasons and dates: ____________________

2. Have you ever been instructed to take ANY medication or take ANY special precautions before any dental appointments? ❑ Yes ❑ No

   If Yes, please explain: ____________________

3. Are you taking ANY drugs, medications or treatments at this time? ❑ Yes ❑ No
   (If you brought a complete written list with you, give that to the receptionist instead.)

   Prescribed: ____________________

   ____

   Over-the-counter (OTC) medications (such as aspirin, Advil, allergy medications, sleeping aids, etc.):

   ____

   Are you having or ever had radiation or chemotherapy treatments? ❑ Yes ❑ No

   If Yes, for how long? ____________________ Name of facility performing the treatment: ____________________

4. Are you taking or have you ever taken / been treated for osteoporosis with a Bisphosphonate (Fosamax, Boniva, Actonel, Reclast) or any other drug? ❑ Yes ❑ No
   How long have you been taking this medication? ____________________

5. Are you allergic to or have you ever experienced an unusual reaction to:
   - ____ Latex
   - ____ Metals or jewelry
   - ____ Dental anesthesia (local)
   - ____ Fluoride
   - ____ Nitrous oxide (laughing gas)
   - ____ General anesthesia

6. Are you allergic to or have you ever had any reaction to any of the following drugs?
   - ____ Penicillin (or related drugs)
   - ____ Tranquilizers (Valium)
   - ____ Tetra cycline
   - ____ Codeine
   - ____ Aspirin / Ibuprofen (Advil, Motrin, Nuprin)
   - ____ Keflex (Cephalexin)
   - ____ Sulfa Drugs
   - ____ Iodine
   - ____ NSAID (Celebrex, Vioxx, Anaprox)
   - ____ Clindamycin (Cleocin)
   - ____ Erythromycin

7. Have you ever had an allergic reaction or unusual response to ANY other medications, drugs, pills, or treatments? ❑ Yes ❑ No

   If Yes, please list: ____________________

(over)

8. Do you have or have you ever had any of the following? (Please check Yes or No for each question)

	Yes	No
Congenital heart defects	____	____
Angina or chest pains	____	____
Atherosclerosis	____	____
Congestive heart failure	____	____
Coronary artery disease	____	____
Heart Surgery If Yes, type & date______________________	____	____
Heart Attack If Yes, date ___________________________	____	____
Rheumatic heart disease / rheumatic fever	____	____
Infective Endocarditis	____	____
Heart valve(s) damage / Mitral valve prolapse	____	____
Artificial heart valve	____	____
Pacemaker	____	____
Stroke or CVA	____	____
High blood pressure	____	____
Low blood pressure	____	____
Anemia	____	____
Hemophilia or bleeding disorder	____	____
Excessive bleeding from any cut or incident	____	____
Diabetes or blood sugar problems A1C Level ______________	____	____
Any artificial joint, joint surgery or prosthesis If Yes, what joint or area:__________________ When was operation done?________________	____	____
Hepatitis, jaundice, or other liver problems	____	____
Any form of cancer	____	____

	Yes	No
Asthma	____	____
Do you use an inhaler?	____	____
Hay fever, skin or food allergies	____	____
Sinus problems	____	____
Tuberculosis, emphysema or lung disorder	____	____
Skin problems	____	____
A sore or wound that bleeds easily or does not heal	____	____
A thyroid problem or disease	____	____
Arthritis	____	____
Glaucoma or any eye disease	____	____
Epilepsy or other seizure disorder	____	____
Any kidney problems	____	____
Ulcers, acid reflux, or stomach problems	____	____
A compromised immune system (Lupus, HIV, AIDS, radiation immune problem, etc.)	____	____
Sexually transmitted disease (STD)	____	____
Any mental health issues	____	____

Women Only:	Yes	No
Are you pregnant? If Yes, what is your due date?_____________	____	____
Do you think you might be pregnant?	____	____
Are you presently nursing?	____	____
Are you using birth control medication?	____	____
Are you taking hormone replacement therapy?	____	____

9. Do you have any other conditions, diseases or medical problems, or is there ANY other information that you would like us to know about, or that we should be made aware of? ❑ Yes ❑ No

If Yes, please explain: ____

____

____

____

CONSENT: To the best of my knowledge, all of the preceding information is correct and if there is ever any change in health, or medications, this practice will be informed of the charges without fail. I also consent to allow this practice to contact any healthcare provider(s) and to have the patient's health information released to aid in care and treatment. I also hereby consent to allow diagnosis, proper health care and treatment to be performed by this practice for the above named individual until further notice.

I understand there are no guarantees or warranties in health or dental care.

Signature____ Date______________________

(Parent or guardian, if patient is a minor)