MEDICAL HISTORY: *check all that apply:*

☐ Heart Murmur	☐ Lung Disease	☐ Artificial Heart Valve	☐ Diabetes
☐ Angina/Chest Pain	☐ HIV/AIDS	☐ Heart pace Maker	☐ Kidney Disease
☐ Heart Attack/Failure	☐ Sinus problems/Allergies	☐ Blood Disease	☐ Thyroid Disease
☐ Congenital Heart Disorder	☐ Asthma	☐ Blood Pressure Problems	☐ Cold Sores
☐ Mitral Valve Prolapse	☐ Snoring/Sleep Disorder	☐ Bleed Easily	☐ Fever Blisters
☐ Rheumatic Fever	☐ Liver Disease	☐ Hepatitis A, B, C	☐ Cancer

Please circle Yes or No:

Are you under a physician's care? Why? ____ **Yes No**

Are you taking any medications? Please list all medications: ______________________ **Yes No**

____

____

____

Are you allergic to any medications? What? (Examples: Penicillin, Sulfa, Codein, Latex, Metals, Acrylic, Tetracycline) **Yes No**

____

____

____

Are you pregnant or trying? Contraceptives? ______________________ Nursing?__________ **Yes No**

Have you had a serious accident or hospitalization? ______________________________ **Yes No**

Normal blood pressure if known? ____ **Yes No**

Joint replacement? ____ **Yes No**

Do you require premed with antibiotics for dental treatment? _______________________ **Yes No**

Authorization:

This information is correct to the best of my knowledge. I understand it will be held in the strictest confidence and only be used to improve communication between the doctor and myself. If there is a change in my health condition or medication I will inform the doctor.

Signature ____ Date_____________

DENTAL HISTORY:

	Yes	No
Do you have a specific dental problem?	☐	☐
Describe ____		
Do you have regular dental care? Last visit? ______________________	☐	☐
Do you floss? How often? ______________________	☐	☐
Do your gums ever bleed? ______________________	☐	☐
Are you interested in improving your smile? ______________________	☐	☐
If so, what would you change about your smile? ______________________		
Does food catch between your teeth?	☐	☐
Do you wish your teeth were straighter?	☐	☐
Do you ever have clicking, popping, or discomfort in your jaw joint?	☐	☐
Have you had periodontal (gum) treatment?	☐	☐
Have you ever had a bad experience with a dentist?	☐	☐
Do you smoke or chew tobacco?	☐	☐
Do you snore?	☐	☐

Last date of X-Rays:

Bite Wings: ______________ Panorex ______________ Full Series ______________

Dental Symptoms/Concerns:

Check all that apply:

Headaches	☐	Loose Teeth	☐	Tingling in Fingers	☐
TMJ Pain	☐	Clenching/Bruxing	☐	Hot & Cold Sensitivity	☐
TMJ Noise	☐	Bells Palsy	☐	Nervousness	☐
Limited Opening	☐	Facial Pain	☐	Insomnia	☐
Ear Congestion	☐	Tender Sensitive Teeth	☐	Trigeminal Neuralgia	☐
Dizziness	☐	Difficulty Chewing	☐	Back Pain	☐
Ringing in Ears	☐	Neck Pain	☐		
Difficulty Swallowing	☐	Postural Problems	☐		

Bob S. Perkins DDS

THANK YOU FOR SELECTING OUR DENTAL TEAM

To help us meet all your healthcare needs, please fill out this form completely in ink.
If you have any questions or need assistance, please ask us and we will be happy to help.

PATIENT INFORMATION (CONFIDENTIAL)

Name ______________________________ Patient Number __________

SSN/SIN ______________ Birthdate ______________ Home Phone ______________

Address ______________________ City ______________ State ________ Zip Code ______________

Email ______________________ Cell Phone ______________________

Circle appropriate option: Minor --------- Single -------- Married --------- Separated --------- Divorced ---------- Widowed ---------- Student (full or part-time)

If Student, Name of School/College ______________________City ______________State ______________

Patient or Parent/Guardian's Employer ______________________ Work phone ______________

Business Address ______________________ City ______________ State ________ Zip ________

Spouse or Parent/Guardian Name______________________ Employer ______________Work Phone ______________

Whom May We Thank for Referring You? ______________________If you were not referred, how did you find us? ______________

Person to Contact in Case of Emergency ______________________ Phone ______________

RESPONSIBLE PARTY

Name of Person Responsible for this Account ______________________ Rel. to Patient ______________

Address ______________________ Home Phone ______________

Email ______________________ Birth Date ______________ Cell Phone ______________ Driver's Lic. __________

Employer ______________________ Work Phone ______________ SSN ______________

Is This Person Currently a Patient in our Office? Yes or No

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

________ Cash __________ Personal Check __________ CC: ___________ Visa __________ MasterCard __________ AMEX ___________ I Wish to Discuss Payment

Please rank the following areas that would keep you from completing recommended dental care (1 being the most important and 4 being the least important:)
______________ Fear of Pain ________________ Cost of Treatment ________________ Missing Work ________________ Lack of Concern ___________Other

INSURANCE INFORMATION

Name of Insured ______________________ Rel. to Patient ______________ Birthdate ______________

SSN/SIN ______________ Name of Employer ______________________Work Phone ______________

Employer Address ______________________ City ______________ State ___________ Zip ______________

Insurance Company ______________________ Group # ______________ Policy ID # ______________

Ins. Co. Address ______________________ City ______________ State ___________ Zip ______________

How Much is Your Deductible? ______________ Max. Annual Benefit ______________ How Much Have You Used? ______________

Do You Have Any Secondary Insurance? _________ Yes _________ No If yes, please turn over page and fill out additional insurance infromation.

SECONDARY INSURANCE INFORMATION

Name of Insured ____ Rel. to Patient _______________ Birthdate ______________

SSN/SIN ________________ Name of Employer ______________________________________Work Phone ____________________

Employer Address ____ City ____________ State _______ Zip ___________

Insurance Company ____ Group # ______________ Policy ID # ____________________

Ins. Co. Address ____ City _________________ State _______ Zip ___________

How Much is Your Deductible? _______________ Max. Annual Benefit _________________ How Much Have You Used? ___________________

AUTHORIZATION AND RELEASE

I certify that I have read and understood the above information to the best of my knowledge. The above questions have been accurately answered. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

____

Signature of Patient (or parent/guardian if minor)