PEPIN VALLEY DENTAL
www.pepinvalleydental.com

Welcome - Please Tell Us About Yourself

Today's Date _____

Patient's Full Name _____ Birthdate_____
First Middle Last

Nickname _____

Single _____ Married _____ Widowed _____ Divorced _____ Social Security # _____

Home Address\Mailing Address_____

City _____ State_____ Zip Code _____

Home Phone _____ Cell Phone _____

Email_____

If a dependent child: Parents Names_____

Employed By_____ Work Phone_____

Name of Spouse _____

Spouse Employed By _____ Work Phone_____

Emergency Contact_____ Phone Number_____

REFERRED BY _____

Preferred Appointment Confirmation _____Cell _____Work _____Home _____TXT _____Email

DENTAL INFORMATION

Do your gums bleed when you brush or floss? ..... Yes ❑ No ❑
Are your teeth sensitive to cold, hot, sweets, or pressure? ..... Yes ❑ No ❑
Does food or floss catch between your teeth? ..... Yes ❑ No ❑
Is your mouth dry? ..... Yes ❑ No ❑
Have you had any periodontal (gum) treatments? ..... Yes ❑ No ❑
Do you have any clicking, popping, or discomfort in the jaw? ..... Yes ❑ No ❑
Do you clench or grind your teeth? ..... Yes ❑ No ❑
Are you currently experiencing dental pain or discomfort? ..... Yes ❑ No ❑
What is the reason for your dental visit today?_____
How do you feel about your smile?_____

ASSIGNMENT AND RELEASE

RESPONSIBLE PARTY: Person responsible for this account (If minor-signature of parent or guardian responsible)

Signature _____

I certify that I (or my dependent) have insurance coverage and assign directly to Pepin Valley Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I'm financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Insurance Subscriber Signature _____

Relationship_____

MEDICAL INFORMATION

Name of Medical Clinic _____ Name of Medical Doctor_____

Do you have any general Health Problems? _____

Do you routinely take any medication? If so list medications:_____

_____

_____

_____

_____

_____

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? ..... Yes ❑ No ❑

Have you been treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ... Yes ❑ No ❑

Have you ever had any of the following? (Please check appropriate box)

Yes	No		Yes	No		Yes	No		Yes	No	
❑	❑	Heart Failure	❑	❑	Stroke	❑	❑	Liver Disease	❑	❑	Cancer
❑	❑	Heart Disease\Attack	❑	❑	Kidney Trouble	❑	❑	Hemophilia	❑	❑	Radiation
❑	❑	Angina Pectoris	❑	❑	Tuberculosis (TB)	❑	❑	Cold Sores			date_____
❑	❑	High Blood Pressure	❑	❑	Emphysema	❑	❑	Blood Transfusion	❑	❑	Chemotherapy
❑	❑	Heart Murmur	❑	❑	Asthma			date_____			date_____
❑	❑	Mitral Valve Prolapse	❑	❑	Hay Fever	❑	❑	Rheumatism	❑	❑	Ulcers
		with or without regurgitation	❑	❑	Sinus Trouble	❑	❑	Glaucoma	❑	❑	Acid Reflux
❑	❑	Congenital Heart Lesions	❑	❑	Allergies or hives	❑	❑	Diabetes	❑	❑	Persistent Heartburn
❑	❑	Artificial Heart Valve	❑	❑	AIDS	❑	❑	Thyroid Disease	❑	❑	Epilepsy\Seizures
❑	❑	Heart Pacemaker	❑	❑	HIV positive test	❑	❑	Anemia	❑	❑	Fainting\Dizzy
❑	❑	Heart Surgery	❑	❑	Hepatitis A (infectious)	❑	❑	Sickle Cell Disease	❑	❑	Rheumatic Fever
		date_____	❑	❑	Hepatitis B (serum)	❑	❑	Pregnant	❑	❑	Scarlet Fever
❑	❑	Artificial Joint\Plates	❑	❑	Chemical Dependency			due date_____	❑	❑	Psychiatric Trmt
		date_____	❑	❑	Do you chew tobacco?	❑	❑	Pop _____(per day)	❑	❑	Other_____
❑	❑	Do you smoke?									
❑	❑	Recent Surgeries (list:) _____									

Have you become sick from, shown any allergy to, or been told not to take:

Yes	No		Yes	No		Yes	No	
❑	❑	Local anesthetic (novocaine)	❑	❑	Antibiotics (Penicillin, etc.)	❑	❑	Other allergies _____

❑ ❑ Do you need antibiotics for dental treatment? If so list:_____

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian _____ **Date** _____

Initials	Date	Initials	Date	Initials	Date	Initials	Date
Initials	Date	Initials	Date	Initials	Date	Initials	Date
Initials	Date	Initials	Date	Initials	Date	Initials	Date
Initials	Date	Initials	Date	Initials	Date	Initials	Date