Welcome to PEPPERMINT DENTAL!

Today's Date: _____

PATIENT INFORMATION

Patient's Name _____ Preferred Name _____ ☐ Male ☐ Female
(Last, First)

Home Address _____
(Street, City, State, Zip)

Home Phone # _____ Cell # _____ Work # _____

SSN (for insur) _____ Birthdate ____ / ____ /____ ☐ Single ☐ Married ☐ Other

Email _____ Who may we thank for referring you? _____

Other family members seen by us _____

Employer _____ Occupation _____

Would you like to receive reminder messages/calls for your appointments by ☐ email ☐ text ☐ phone

NEIGHBOR OR RELATIVE NOT LIVING WITH YOU

Name _____ Relation _____ Home Phone # _____ Other # _____

SPOUSE INFORMATION

His/Her Name _____ Birthdate ____ / ____ /____ SSN _____

Cell # _____ Work # _____

PARENTS INFORMATION FOR CHILD

Mother's Name _____ ☐ Responsible for account

Home Phone # _____ Cell # _____ Work # _____

Email _____ Birthdate ____ / ____ /____

Father's Name _____ ☐ Responsible for account

Home Phone # _____ Cell # _____ Work # _____

Email _____ Birthdate ____ / ____ /____

Parent's Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other

INSURANCE

Primary Dental Insurance Name _____ Phone # _____

Insurance Co. Address _____
(Street, City, State, Zip)

Group/Policy # _____ Subscriber's Name _____ Relationship to Patient _____

Subscriber's ID#/SSN _____ Subscriber's Birthdate ___ / ___ /___ Subscriber's Employer _____

Secondary Dental Insurance Name _____ Phone # _____

Insurance Co. Address _____
(Street, City, State, Zip)

Group/Policy # _____ Subscriber's Name _____ Relationship to Patient _____

Subscriber's ID#/SSN _____ Subscriber's Birthdate ___ / ___ /___ Subscriber's Employer _____

DENTAL HISTORY FOR YOU OR YOUR CHILD

What are your present dental concerns? _____

_____

Are you currently in pain? ☐ yes ☐ no
Are you happy with the way your smile looks? ☐ yes ☐ no
If not, what would you change? _____

_____

Do you require antibiotics before dental work? ☐ yes ☐ no
Have you experienced problems with previous dental work? ☐ yes ☐ no
Do you now or ever have had any pain in your jaw joint (TMJ/TMD)? ☐ yes ☐ no
Do you grind or clench your teeth? ☐ yes ☐ no
Your current dental health is ☐ Good ☐ Fair ☐ Poor
Do you brush daily? ☐ yes ☐ no Floss daily? ☐ yes ☐ no

Please list anything else used in addition to brush and floss:

_____

Would you like whiter teeth? ☐ yes ☐ no
Do your gums ever bleed? ☐ yes ☐ no
Do you have mobility in your teeth? ☐ yes ☐ no
Have you ever had periodontal disease? ☐ yes ☐ no
Are your teeth sensitive to heat, cold or anything else?

_____

Previous Dentist _____ Last Visit _____
Why did you leave your previous dentist? _____
What did you like most & least about any dentist you have seen?

_____

FOR CHILD:

Speech problems? ☐ yes ☐ no
Thumb/finger sucking? ☐ yes ☐ no
Bottle at night? ☐ yes ☐ no

Grinding/clenching teeth? ☐ yes ☐ no
Is your water fluoridated? ☐ yes ☐ no
Taking fluoride supplements? ☐ yes ☐ no

Do you have any other concerns or question's not already listed above?

_____

MEDICAL HISTORY FOR YOU OR YOUR CHILD

Physician's Name _____
Address _____
Phone # _____ Date of Last Visit _____
Your current physical health is ☐ Good ☐ Fair ☐ Poor
Are you currently under the care of a physician? ☐ Yes ☐ No
If yes please explain _____
Do you use tobacco in any form? ☐ Yes ☐ No
Have you ever taken Fosamax or Biphosphonate? ☐ Yes ☐ No
Have you ever taken Phen-Fen, Redux or Pondimin ☐ Yes ☐ No

Are you allergic to any of the following?

Y N Aspirin	Y N Erythromycin	Y N Sedative
Y N Barbiturates	Y N Jewelry/Metals	Y N Sulfa Drugs
Y N Codeine	Y N Latex	Y N Tetracycline
Y N Dental Anesthetic	Y N Penicillin	Y N Other

Please list additional drugs/materials that cause allergic reactions

_____

For Women: Are you Pregnant? ☐ No ☐ Yes. Week# ___ ☐ Unsure
Are you nursing? ☐ No ☐ Yes

Are you taking any of the following?

Y N Antibiotics	Y N Blood Thinners	Y N Insulin/Diabetes Drugs	Y N Steroids/Cortisone
Y N Antihistamines	Y N Blood Pressure Medicine	Y N Nitroglycerin	Y N Thyroid Medicine
Y N Aspirin	Y N Digitalis/Heart Medicine	Y N Recreational Drugs	Y N Tranquilizers

Are you taking any prescription, over-the-counter drugs, herbal remedies, vitamins or minerals not listed above? ☐ Yes ☐ No
If yes please list each one: _____

Do you or have you experienced the following?

Y N Abnormal Bleeding	Y N Diabetes	Y N Heart Surgery	Y N Osteoporosis/Paget's
Y N ADD/ADHD	Y N Emphysema	Y N Hemophilia	Y N Pacemaker
Y N Alcohol/Drug Addiction	Y N Epilepsy/Seizures	Y N Hepatitis	Y N Psychiatric Care
Y N Anemia	Y N Fainting Spells	Y N Herpes	Y N Rheumatic/Scarlet Fever
Y N Arthritis	Y N Fever Blisters	Y N High Blood Pressure	Y N Shingles
Y N Artificial Bones/Joints	Y N Glaucoma	Y N HIV+/AIDS	Y N Sickle Cell Disease
Y N Artificial Valves	Y N Handicaps/Disabilities	Y N Hospitalizations	Y N Steroid Therapy
Y N Asthma	Y N Hay Fever/Sinus Problems	Y N Kidney Problems	Y N Stroke
Y N Cancer	Y N Hearing Impairment	Y N Liver Disease	Y N Thyroid Problems
Y N Chemotherapy/Radiation	Y N Heart Attack	Y N Low Blood Pressure	Y N Tuberculosis (TB)
Y N Congenital Heart Defect	Y N Heart Murmur	Y N Mitral Valve Prolapse	Y N Ulcers or GI Problems

Please list any serious medical condition(s) that you have had: _____

AUTHORIZATIONS FOR YOU OR YOUR CHILD

I affirm that the information I have given is correct, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my /my child's medical status. I authorize the staff to perform the necessary dental services I/ my child may need.

I assign directly to Peppermint Dental/Dr. Sheryl Lee all insurance benefits, otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I herby authorize Peppermint Dental to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic. I acknowledge receipt of the HIPAA Notice of Privacy Practices.

_____

signature (self or guardian) date