Ben Samuelson, DMD, MS

WE WOULD LIKE TO WELCOME YOU TO OUR OFFICE.
PLEASE COMPLETE **BOTH** SIDES OF THIS FORM. ALL INFORMATION IS CONFIDENTIAL. THANK YOU.

PATIENT INFORMATION

TODAY'S DATE: ______________

PATIENT'S NAME: ________________________________ PREFERS TO BE CALLED: ________________________________

ADDRESS: ____ CITY/STATE/ZIP: ________________________________

HOME PHONE: ____________________________ DATE OF BIRTH: ____________________ AGE: ________ SEX: ________

SCHOOL: ____ GRADE: _____________

E-MAIL: ____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? ____

NAME & AGE OF OTHER SIBLINGS OR FAMILY MEMBERS TREATED HERE: ____

____

RESPONSIBLE PARTY INFORMATION

(Adult patients, please complete this section)

NAME: _____________________ MARITAL STATUS: __________________ RELATIONSHIP TO PATIENT: _________________

SSN: ______________________________ DATE OF BIRTH: ____________________

ADDRESS: ____ CITY/STATE/ZIP: ________________________________

HOME PHONE: _____________________ WORK: ___________________________ CELL: ____________________________

E-MAIL: ____

EMPLOYER: _______________________ OCCUPATION: ____________________________ YEARS EMPLOYEED: _________

SPOUSE'S NAME: ______________________________________ RELATIONSHIP TO PATIENT: _______________________

DATE OF BIRTH: ____________________

HOME PHONE: _____________________ WORK: ___________________________ CELL: ____________________________

E-MAIL: ____

EMPLOYER: _______________________ OCCUPATION: ____________________________ YEARS EMPLOYEED: _________

EMERGENCY CONTACT INFORMATION

1. EMERGENCY CONTACT NAME: ____
   PHONE: ______________________________ RELATIONSHIP TO PATIENT: ______________________________
2. EMERGENCY CONTACT NAME: ____
   PHONE: ______________________________ RELATIONSHIP TO PATIENT: ______________________________

DENTAL INSURANCE INFORMATION

POLICY HOLDER'S FULL NAME: ___________________________________ SSN: ______________________ DOB: ________

POLICY HOLDER'S ADDRESS: ____

INSURANCE COMPANY: ____________________ GROUP #: __________________ CONTRACT/ID #: ___________________

INSURANCE COMPANY ADDRESS: ____

INSURANCE PHONE #: _____________________ POLICY HOLDER'S EMPLOYER: ___________________________________

DO YOU HAVE DUAL COVERAGE? ___________________ (*if yes please fill in below*)

POLICY HOLDER'S FULL NAME: ___________________________________ SSN: ______________________ DOB: ________

POLICY HOLDER'S ADDRESS: ____

INSURANCE COMPANY: ____________________ GROUP #: __________________ CONTRACT/ID #: ___________________

INSURANCE COMPANY ADDRESS: ____

INSURANCE PHONE #: _____________________ POLICY HOLDER'S EMPLOYER: ___________________________________

MEDICAL AND DENTAL HEALTH INFORMATION

PATIENT'S DENTIST: ______________________________ DATE OF LAST DENTAL VISIT: __________

DO YOU NEED A REFERRAL TO A DENTIST? ____________

WHAT CONCERNS YOU THE MOST ABOUT YOUR TEETH? ______________________________

HAS AN ORTHODONTIST PREVIOUSLY BEEN CONSULTED? _____________

ARE ANTIBIOTICS NECESSARY FOR TEETH CLEANING? __________

IS THERE ANY DENTALWORK THAT NEEDS TO BE COMPLETED PRIOR TO TREATMENT? __________

PATIENT'S PHYSICIAN: ______________________________ DATE OF LAST PHYSICAL EXAM: ______________

IS THE PATIENT UNDER THE CARE OF A PHYSICIAN AT THIS TIME? _____________

If yes, please explain: ______________________________

LIST ANY MEDICATIONS BEING TAKEN AT THIS TIME: ______________________________

____

LIST ALL ALLERGIES: ______________________________

____

HAS THE PATIENT EVER HAD ANY OF THE FOLLOWING MEDICAL OR DENTAL PROBLEMS?

PLEASE EXPLAIN ANY MEDICAL OR DENTAL PROBLEMS THAT YOU HAVE HAD:

ABNORMAL BLEEDING	YES/NO	LATEX ALLERGY	YES/NO
HEMOPHILIA / PROLONGED BLEEDING	YES/NO	PLASTIC / METAL ALLERGY	YES/NO
HEART MURMUR OR MVP	YES/NO	ASTHMA OR HAY FEVER	YES/NO
BRUISE / BLEED EASILY	YES/NO	SINUS PROBLEMS	YES/NO
ANEMIA	YES/NO	TONSILS / ADENOID PROBLEMS	YES/NO
HEART VALVE REPLACEMENT	YES/NO	TUBERCULOSIS / POSITIVE PPD	YES/NO
HEART PROBLEMS	YES/NO	FREQUENT COLDS / SORE THROAT	YES/NO
HIGH BLOOD PRESSURE	YES/NO	BONE DISORDERS	YES/NO
TOOTH/JAW TRAUMA	YES/NO	ARTHRITIS / OSTEOPOROSIS	YES/NO
CLENCHING / GRINDING	YES/NO	JOINT REPLACEMENT	YES/NO
JAW CLICKING / POPPING	YES/NO	THYROID PROBLEMS	YES/NO
PAINFUL JOINTS	YES/NO	CANCER OR TUMOR	YES/NO
DENTAL PAIN	YES/NO	PREVIOUS SURGERIES	YES/NO
EXTRA TEETH	YES/NO	EAR INFECTIONS	YES/NO
MISSING TEETH	YES/NO	HEPATITIS	YES/NO
NERVOUS DISORDERS	YES/NO	ALCOHOLISM / DRUG ADDICTION	YES/NO
LIVER DISEASE	YES/NO	EPILEPSY/ CONVULSIONS / SEIZURES	YES/NO
TONGUE THRUST	YES/NO	FAINTING OR DIZZINESS	YES/NO
MOUTH BREATHING	YES/NO	KIDNEY DISEASE	YES/NO
FINGER / THUMB SUCKING	YES/NO	SEXUALLY TRANSMITTED DISEASE	YES/NO
LIP / TONGUE BITING	YES/NO	AIDS / HIV POSITIVE	YES/NO
SMOKE/CHEW TOBACCO	YES/NO	DIABETES	YES/NO
SPEECH PROBLEMS	YES/NO	PREGNANT NOW	YES/NO
COLD SORES / FEVER BLISTERS	YES/NO	DISABILITIES	YES/NO

AFFIRMATION

I AFFIRM THAT THE INFORMATION THAT I HAVE GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE. IT WILL BE HELD IN THE STRICTEST OF CONFIDENCE AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE IMMEDIATELY OF ANY CHANGES IN MEDICAL STATUS. I UNDERSTAND THAT WHERE APPROPRIATE, CREDIT REPORTS MAY BE OBTAINED.

______________________________ ______________
PATIENT/PARENT/LEGAL GUARDIAN DATE

OFFICE USE ONLY

I VERBALLY REVIEWED THE MEDICAL / DENTAL INFORMATION ABOVE WITH THE PATIENT / PARENT / LEGAL GUARDIAN.

______________________________ ______________
SIGNED DATE