Patient Information

Marianna Baker, D.D.S.
Family Dentist

Today's Date ____________________

Thank you for choosing Marianna Baker, D.D.S. as your family dentist. We want you to keep your natural smile, and to help you reach and maintain good oral health. Please fill out completely. The better we communicate, the better we can care for you.

Patient Information

Name ____________________

I prefer to be called __________ ☐ Male ☐ Female

Address ____________________

City/State/Zip ____________________

☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed

Birthday ____________________

SS# ____________________

Phone Number ____________________

Cell Phone ____________________

Work Phone ____________________

Email ____________________

Best time/way to reach you ____________________

Whom may we thank for referring you? ____________________

____

Employer

Occupation ____________________

Employer ____________________

Employer Address ____________________

City/State/Zip ____________________

How Long There ____________________

Emergency Contact

Name ____________________

Phone Number ____________________

Cell Phone ____________________

Relationship ____________________

Person Responsible for Account

Name ____________________

Primary Insurance

Dental Insurance: ☐ Yes ☐ No

Policy Number ____________________

Company Name ____________________

Company Address ____________________

City/State/Zip ____________________

Phone ____________________

Insured Name ____________________

Insured SS# ____________________

Insured Birthday ____________________

Insured Employer ____________________

Employer Address ____________________

City/State/Zip ____________________

Relationship ____________________

____

Secondary Insurance

Dental Insurance: ☐ Yes ☐ No

Policy Number ____________________

Company Name ____________________

Company Address ____________________

City/State/Zip ____________________

Phone ____________________

Insured Name ____________________

Insured SS# ____________________

Insured Birthday ____________________

Insured Employer ____________________

Employer Address ____________________

City/State/Zip ____________________

Relationship ____________________

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Payment is due in full at the time of treatment.
I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature ____________________ Date ____________________

Medical History

Do you have a personal physician? ☐Yes ☐No

Physician's name ______________________

Phone number ______________________

Date of last visit ______________________

Are you currently under care of the physician? ☐Yes ☐No

Please explain ______________________

____

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Current physical health: ☐Good ☐Fair ☐Poor

Do you smoke or use tobacco in any other form? ☐Yes ☐No

Have you had any metal rods, pins, or implants? ☐Yes ☐No

For Women

Are you using a prescribed of birth control? ☐Yes ☐No

Are you pregnant? ☐Yes ☐No Week # __________

Are you nursing? ☐Yes ☐No

Have you ever had of the following medical problems?

- ☐ Abnormal Bleeding/Hemophilia
- ☐ AIDS
- ☐ Alcohol/Drug Abuse
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Bones/Joints/Valves
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Cancer/Chemotherapy
- ☐ Colitis
- ☐ Congenial Heart Defect
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting Spells
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attacks/Surgery
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ Herpes/Fever Blisters
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Hospitalization
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lupus
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Psychiatric Problems
- ☐ Radiation Treatment
- ☐ Rheumatic/Scarlet Fever
- ☐ Seizures
- ☐ Shingles
- ☐ Sickle Cell Disease/Traits
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis (TB)
- ☐ Ulcers
- ☐ Venereal Disease

☐ Other ______________________

____

____

Medications

Please list all prescription/over-the-counter drugs you are cureently taking ______________________

____

Have you ever taken Fosamax, or any other bisphosphonate? ☐Yes ☐No

Have you taken Fen-phen? ☐Yes ☐No

Allergies

Are you allergic to any of the following?

☐ Aspirin ☐ Erythromycin ☐ Penicillin

☐ Codeine ☐ Jewelry / Metals ☐ Tetracycline

☐ Dental Anesthetic ☐ Latex

☐ Other ______________________

Dental History

Why have you come to the dentist today? ______________________

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Are you currently in pain? ☐Yes ☐No

Do you require antibiotics before for dental treatment? ☐Yes ☐No

Your current dental health is: ☐Good ☐Fair ☐Poor

Have you ever had a serious/difficult problem associated with any previous dental work? ☐Yes ☐No

Do you floss daily? ☐Yes ☐No Brush daily? ☐Yes ☐No

Type of bristles on your toothbrush? ☐ Hard ☐ Medium ☐ Soft

Have you ever had gum treatment? ☐Yes ☐No

Do your gums ever bleed? ☐Yes ☐No

Ever itch? ☐Yes ☐No

Have you ever had periodontal disease? ☐Yes ☐No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ☐Yes ☐No

Are your teeth sensitive to heat, cold, or anything else?

____

Do you have any loose teeth? ☐Yes ☐No

Do you still have wisdom teeth? ☐Yes ☐No

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

Signature ______________________ Date ______________________