GLACIER PEAK
DENTISTRY

PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

PERSONAL

Patient Name_____
Last First MI (Preferred)

Birthdate_____ SS#_____ DL# _____ Gender: ◯M ◯F Married: ◯Y ◯N

Work Phone_____ Cell Phone_____ Email_____

If patient is under 18 yrs, please also complete the following:

Guarantor *Name*_____
Last First MI (Preferred)

Birthdate_____ SS#_____ DL# _____ Gender: ◯M ◯F Married: ◯Y ◯N

Work Phone_____ Cell Phone_____ Email_____

Student status if dependent over 19 (for ins) ◯Nonstudent ◯Full time ◯Part time

How did you hear about us? (Please be specific so we can thank them!)_____

ADDRESS AND HOME PHONE

Check circle if same for entire family: ◯

Address_____

Address 2_____

City_____ State_____ Zip_____

Home Phone_____

INSURANCE POLICY 1

Patient relationship to subscriber: ◯Self ◯Spouse ◯Child

Subscriber Name_____ Sub.ID # _____ Sub.DOB_____

Insurance Company _____ Phone_____

Employer_____ Group Name_____ Group #_____

INSURANCE POLICY 2

Patient relationship to subscriber: ◯Self ◯Spouse ◯Child

Subscriber Name_____ Sub.ID # _____ Sub.DOB_____

Insurance Company _____ Phone_____

Employer_____ Group Name_____ Group #_____

FINANCIAL AGREEMENT

* For my convenience, this office may release my information to my insurance, and receive payment directly from them.
* Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible.
* For insured and non-insured patients, if sent to collections, I agree to pay a **$30 collection fee** and all related fees and court costs
* Treatment plans may change, and I will be responsible for the work actually done.

Signature_____ Date_____

MEDICAL HISTORY

Name of Medical Doctor:_____ City/State_____

Emergency Contact_____ Phone_____Relationship_____

List all the medications or drugs you are now taking:

[ ] None

_____

_____

_____

_____

Check medications or drugs you are allergic to:

◯ None
◯ Aspirin
◯ Codeine/Other Narcotics
◯ Erythromycin
◯ Latex Rubber
◯ Local Anesthetics
◯ Metals
◯ Penicillin
◯ Sulfa Drugs
◯ Other: _____

Check any medical conditions you may have:

◯ None
◯ AIDS/HIV
◯ Alcohol/Drug Abuse
◯ Anemia/Leukemia
◯ Anorexia/Bulimia
◯ Arthritis
◯ Asthma/Hay Fever
◯ Blood Clotting Problems
◯ Blood Transfusion
◯ Bronchitis
◯ Cancer/Tumor or Growth
◯ Cardiac Pacemaker
◯ Chest Pain Upon Exertion
◯ Damage Heart Valve
◯ Diabetes
◯ Emphysema
◯ Epilepsy
◯ Fainting Spells/Seizures
◯ Fever Blisters/Herpes
◯ Frequent Headaches
◯ Frequent Dry Mouth/Sjogrens
◯ Gall Bladder Trouble
◯ Heart Attack/Stroke
◯ Heart Disease/Angina
◯ Heart Murmur
◯ Hepatitis/Jaundice
◯ High Blood Pressure
◯ Hives/Skin Rash
◯ Joint Replacement, Date: _____
◯ Kidney/Bladder Trouble
◯ Liver Disease
◯ Low Blood Pressure
◯ Mental Health Problems
◯ Mitral Valve Prolapse
◯ Persistent Diarrhea
◯ Rheumatic Fever
◯ Rheumatic Heart Disease
◯ Sexually Transmitted Disease
◯ Sinus Trouble
◯ Stomach Ulcers
◯ Thyroid Problems
◯ Tuberculosis
◯ Other: _____

Tobacco use? If so, what kind and how much?_____

WOMEN ONLY- Are you pregnant or do you have reason to believe you may be? ◯Yes / ◯No

DENTAL HISTORY

Reason for today's visit:_____ Are you in pain? ◯Yes / ◯No

Unusual reaction to dental injections?_____

New patients:

Name of former dentist_____ City/State_____

Date of last cleaning and exam_____

How would you rate the general health of your mouth? ◯Excellent / ◯Good / ◯Fair / ◯Poor

Are you:

Nervous about dental treatment? ◯Very / ◯Somewhat / ◯Slightly / ◯No

Happy with your smile? ◯Yes / ◯No

Interested in whiter teeth? ◯Yes / ◯No

Interested in straighter teeth? ◯Yes / ◯No

Interested in replacing mercury/silver fillings? ◯Yes / ◯No

By signing below, I certify that all of the above information is true to the best of my knowledge.

Patient/Guardian Name (printed) **Date**

_____ _____

Patient/Guardian Signature Doctor's Signature

_____ _____