Heather Neal Blanchard DDS

Creating Beautiful Smiles

PATIENT INFORMATION:

Date: ______________________________

Legal Name: ____________________________________ Preferred Name: ______________________

Birth Date: ______________ SSN: ___________________ Male: ____________ Female: __________

Mailing Address: _________________________________ Home ______________________________

Email ____ Cell #: ____________________________

Employer: ____________________________________ Work #: ___________________________

How would you prefer to receive appointment confirmation?

Voicemail_____ Text______ Email________ Married / Single / Divorced / Minor / Other

Who may we thank for referring? ___________________ Emergency Name & #: _________________

RESPONSIBLE PARTY: ***(if patient is a minor)***

Legal Name: ____________________________________ Preferred Name: ______________________

Birth Date: ______________ SSN: ___________________ Male: ____________ Female: __________

Mailing Address: _________________________________ Home #: ____________________________

____ Cell #: ____________________________

Employer: ____________________________________ Work #: ____________________________

Married / Single / Divorced / Other: __________________

INSURANCE INFORMATION:

Primary:

Name of Subscriber: ______________________________ Birthdate: __________________________

Employer: ____________________________________ SSN: ______________________________

Insurance Company Name: _________________________ Phone #: ___________________________

Group #: _____________________________________ ID# _______________________________

Secondary:

Name of Subscriber: ______________________________ Birthdate: __________________________

Employer: ____________________________________ SSN: ______________________________

Insurance Company Name: _________________________ Phone #: ___________________________

Group #: _____________________________________ ID# _______________________________

Medical History:

Your current physical health is: Excellent Good Fair Poor

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

Please explain: ____________________

Name of physician: ____________________ Phone#: ____________

Date of last physical exam: ____________________

Are you taking any prescription medications? Yes No If yes, please list below:

Name of medication: Purpose:

____

____

____

Do you smoke or use chewing tobacco? Yes No If yes, how much per day? __________

For Women:

Are you pregnant? Yes No If yes, how many months?_________ Are you nursing? Yes No
Are you taking birth control pills? Yes No
Do you plan on becoming pregnant in the near future and when? ____________________

Have you had any serious medical problems within the past 5 years? Yes No If yes, please explain:

____

Have you ever had, or been treated for any of the following diseases or medical problems?

Yes No		Yes No		Yes No	
	Heart Attack/Stroke		Heart murmur/Rheumatic fever		Heart Defects
	Hepatitis/Jaundice		High/Low Blood Pressure		Pacemaker
	Epilepsy/Seizures/Fainting		Abnormal Bleeding		Hemophilia
	Cancer/Chemotherapy/Radiation		Kidney problems		Thyroid problems
	Psychiatric problems		Diabetes		Mitral Valve Prolapse
	Tuberculosis		Drug/Alcohol abuse		Liver Disease
	Anemia		Arthritis		Venereal Disease
	Artificial Bones/Joints/Valves		Asthma/Breathing problems		Emphysema
	Blood Transfusion		Herpes/Fever Blister		Shingles
	Colitis		Glaucoma		Sickle Cell Disease
	HIV+/AIDS		Migraine Headaches		Sinus problem

Are you allergic to any of the following?

Yes No		Yes No		Yes No	
	Aspirin		Sulfa		Tetracycline
	Codeine		Latex		Other:___________
	Dental Anesthetics		Penicillin		________________________

Dental Questionnaire:

1. Do you need to be premedicated before dental treatment (history of heart murmur, bacterial endocarditis, mitral valve prolapse, etc., presence of metal plates, pins and rods in the body)? Yes No

2. Why have you come to the dentist today? ____________________

3. These are the things that are important to me about my dental health: ____________________

____

4. Date of last dental visit: __________Previous dentist's name: __________ Phone#: __________

5. Are you currently in pain or discomfort? Yes No
If yes, please explain: ____________________

6. Have you ever had a serious/difficult problem associated with any previous dental work? Yes No
If yes, please explain: ____________________

7. Does dental treatment make you nervous? No Somewhat Extremely

8. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? Yes No

9. Do you have any problems with bad breath? Yes No

10. Do your gums ever bleed when you brush? Yes No ...when you floss? Yes No

11. If you could easily and safely whiten your teeth, would you be interested? Yes No

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

13. Do you grind or clench your teeth? Yes No

14. Do you snore loudly on most nights? Yes No

15. Has it ever been reported to you that you stop breathing or gasp during sleep? Yes No

16. Do you have any daytime sleepiness or fatigue? Yes No

17. Check One Box For Each Section:

A.
- My mouth is very comfortable.
- My mouth is moderately comfortable.
- My mouth is uncomfortable.

B.
- I think the appearance of my mouth is excellent.
- I am satisfied with the appearance of my mouth.
- I am dissatisfied with the appearance my mouth.

C.
- I will do anything to keep my natural teeth.
- I want to keep my teeth, but have a certain budget of time and money that I am willing to spend on them.

D.
- I have always done the best that was recommended for my dental health.
- I have not done what dentists have recommended to me.
- I rarely go, and don't care much about having any dental work completed.

E.
- I have put dentistry for myself and family high on my priority list.
- I put dentistry for myself and my family low on my priority list.
- Dentistry is on my list but it's hard to find .

F.
- I have set goals for my oral health with a previous dentist.
- I want to set goals concerning my dental health.
- I don’t care about setting goals for my oral health.

18. Insurance companies now allow for “functionally acceptable work,” whereas, in the past their coverage was for “quality work.” It is our desire to provide our patients with the highest quality work within their financial capabilities and desires. What is important to you? (check one)
- The highest quality dentistry available.
- The most economical treatment plan.
- Dentistry limited to insurance coverage.
- A combination of the above. Please explain:

____
____

19. The following best describes my reason for seeking dental care (please check only one).
- Desire to avoid pain and prevent future problems.
- Desire to look my best and be more attractive.
- Desire to enjoy better health and feel good about myself.
- Desire to avoid problems early, save time, and to avoid preventable expenses in the future.
- Other____________________

20. Has anything kept you from receiving dental treatment in the past? Yes No
What was it?____

21. What I expect from my dentist:____
____

22. What are some questions about dentistry and oral health that you have never had adequately answered?
____

I understand that the information that I have given today is correct to the best of my knowledge. I 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. I assume the financial responsibility and obligation associated with the treatment I consented to.

Signature____ Date: _________________________________