

## Welcome To The Frederick Dental Group

### Patient Information:

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Birth Date \_\_\_\_\_ SS # \_\_\_\_\_ Sex M F

Home # ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_

Cell # ( ) \_\_\_\_\_ Best way to reach you during the day? \_\_\_\_\_

Email \_\_\_\_\_

Single Married Widowed Separated Divorced

Emergency Contact Person Name/Relationship/Phone: \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer Phone ( ) \_\_\_\_\_ Whom may we thank for referring you? \_\_\_\_\_

If full time student, list school and hours/week \_\_\_\_\_

### Dental Insurance Information:

Name of person responsible for this account? \_\_\_\_\_ SS#: \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Subscriber ID \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_

### Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with the above insurance co. and assign directly to Frederick Dental Group or their dentists all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

\_\_\_\_\_  
 Responsible Party Signature Relationship Date

### Health History:

Physicians Name \_\_\_\_\_ Date of last physical \_\_\_\_\_

Check if you have had any of the following:

AIDS/HIV	Anemia	Arthritis, Rheumatism
Artificial Heart Valves	Artificial Joints	Asthma
Back Problems	Bleeding with extractions	Blood disease
Blood Disease	Cancer	Chemical Dependency
Chemotherapy	Circulatory Problems	Congenital Heart Probs.
Cortisone Treatments	Cough, persistent or	Diabetes
Emphysema	bloody	Epilepsy
Fainting or dizziness	Glaucoma	Headaches
Acute narrow angle glaucoma	Cardiac Transplant	Mitral Valve Prolapse
Have U had bacterial endocarditis	Hepatitis Type ____	Herpes
High Blood Pressure	Heart Attack	Kidney Disease
Jaw Pain	Low Blood Pressure	Liver Disease

**Health History (cont'd)**

Jaundice	Pacemaker	Nervous Problems
Psychiatric Care	Rheumatic heart disease	Radiation Treatment
Respiratory Disease	Scarlet Fever	Shortness of Breath
Sinus Trouble	Skin Rash	Stroke
Swelling of Feet or ankles	Swollen Neck Glands	Thyroid Problems
Tuberculosis	Tumors or growths	Ulcer
Venereal Disease (Type _____)	Unexplained Weight Loss	Sleep Apnea

Do you wear contact lenses?    Yes    No

**Women:** Are you pregnant?    Yes    No    Are you nursing?    Yes    No  
 If no, are you planning a pregnancy?    Yes    No

If yes, Due Date: \_\_\_\_\_    Taking Birth Control Pills?    Yes    No

**Medications: List any prescription medications you are currently taking:**

\_\_\_\_\_

**Medications: List any over the counter or herbal supplements you are currently taking:**

\_\_\_\_\_

Do you drink Grapefruit Juice?    Yes    No

**Allergies: Check all that apply**

Aspirin	Local Anesthetic	Codeine	Barbituates	Iodine	Penicillin
Sulfa Drugs	Latex	Nickel/Metals	Other _____		

**Dental Information**

-Reason for today's appt? \_\_\_\_\_

-Date of Last Dental Exam? \_\_\_\_\_ Date of last x-rays? \_\_\_\_\_

-Previous dentist: \_\_\_\_\_ Reason for leaving them: \_\_\_\_\_

-How often do you see your dentist each year?  
 0-2x/year    3-4x/year    4 or more times a year

-How often do you brush your teeth/day?  
 0    1    2    3+

-What type of toothbrush do you use?  
 Manual    Soft    Medium    Hard  
 Electric    Sonicare    Oral B Braun    Other: \_\_\_\_\_

-How often do you floss your teeth/day?  
 0    1    2    3+

Do you suffer from any of the following? Check all that apply.

Chronic headaches	Clicking or popping of the jaw joint
Jaw pain	Dislocation of the jaw joint (locked jaw)
Sore muscles in the face	Ear pain

-Do you have any of the following conditions? Check all that apply.

Bleeding/swollen gums	Grinding teeth	Mouth Pain
Broken/lost fillings	Cavities/Decay	Sensitivity to cold/hot/sweet
Loose/Lost Teeth	Ulcers in your mouth	Sensitivity when biting
Food stuck in teeth	Halitosis (Bad Breath)	Broken bridge/denture

-What types of dental treatment have you had in the past? Check all that apply.

- Preventive therapy (cleanings, regular checkups)
- Restorative (fillings-silver or white, inlays/onlays)
- Periodontal therapy (gum treatment including deep cleanings and or continued Periodontal maintenance, gum surgery)
- Endodontic therapy (root canals, re treatment of root canal, endodontic surgery)
- Oral surgery (extraction of baby or adult teeth, removal of wisdom teeth, bone surgery)
- Prosthodontic therapy
  - Crowns/Bridges                      Dentures                      Implants
- Orthodontic therapy (braces-removable or fixed)
- Retainers (removable or fixed)
- Splint therapy (TMJ appliance, nightguard or other occlusal appliance)
- Cosmetic dentistry (Teeth Bleaching/Whitening, Bonding/veneers)

Do you consume/use any of the following? Check all that apply

- Cigarettes-How many per day? \_\_\_\_\_ For how many years? \_\_\_\_\_
- Cigars-How many per day? \_\_\_\_\_ For how many years? \_\_\_\_\_
- Smokeless tobacco
- Chewing gum
- Sodas/Juices-Quantity per day? \_\_\_\_\_
- Coffee/Tea-Quantity per day? \_\_\_\_\_
- Alcohol-Drinks per week? \_\_\_\_\_
- Controlled substances such as:
  - Marijuana
  - Cocaine or derivatives
  - Barbituates/Sleeping pills
  - Opiates
  - Narcotic Painkillers
  - Other? \_\_\_\_\_

-Please indicate your frequency of drug use and whether you inhale or inject?

- Daily                                      Inhale
- Weekly                                    Inject
- Monthly

-Are you happy with the shape, alignment and color of your teeth? \_\_\_\_\_

-What would you like to change about your teeth or your smile?

-Please tell us your level of comfort with dental care? Check one:

- I am completely comfortable having dental care
- I am a little nervous when visiting the dentist
- I try to avoid dental care unless necessary
- I am extremely phobic about dental care

- Are you interested in sedation dentistry for your dental care?    Yes                      No

**All information released to this office is confidential under the doctor/patient privilege and the HIPAA privacy practices. I, \_\_\_\_\_, acknowledge that I am aware of this**

**offices privacy practices and have reviewed the posted Notice of Privacy Practices. I understand I have a right to a copy of these privacy policies.**

\_\_\_\_\_  
Patient, Parent/Guardian Signature

\_\_\_\_\_  
Date