BOYSON DENTAL

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(319) 393-4019

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. Please complete this form to the best of your knowledge. If you have any questions, please do not hesitate to call us.

Date _____

SS # _____

Patient Information (CONFIDENTIAL)

Patient's Sex ☐ *F* ☐ *M*

Name _____ *Birthdate* _____ *Home Phone* _____

Address _____ *City* _____ *State* _____ *Zip* _____

Email _____ *Cell Phone* _____

Do you prefer to receive calls at your: ☐ *Home* ☐ *Work* ☐ *Cell Phone*

Check Appropriate Box: ☐ *Minor* ☐ *Single* ☐ *Married* ☐ *Divorced* ☐ *Widowed* ☐ *Separated*

If Student, Name of School/College _____ *City* _____ *State* _____ ☐ *Full Time* ☐ *Part Time*

Patient or Parent/Guardian's Employer _____ *Work Phone* _____

Business Address _____ *City* _____ *State* _____ *Zip* _____

Spouse or Parent/Guardian's Name _____ *Employer* _____ *Work Phone* _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ *Phone* _____

Person Responsible for Payment

Name of Person Responsible for this Account _____ *Relationship to Patient* _____

Address _____ *Home Phone* _____

Email _____ *Cell Phone* _____

Driver's License # _____ *Birthdate* _____

Employer _____ *Work Phone* _____ *SS# / SIN* _____

Is this Person Currently a Patient in our Office? ☐ *Yes* ☐ *No*

For your convenience, we offer the following methods of payment. Please check the option you prefer for payment in full at each appointment.

☐ *Cash* ☐ *Personal Check* *Credit Card* ☐ *VISA* ☐ *Master Card* ☐ *Discover* ☐ *I wish to discuss the office's payment policy.*

Insurance Information - Dental

Name of Insured _____ *Relationship to Patient* _____

Birthdate _____ *SS# / ID#* _____ *Date Employed* _____

Name of Employer _____ *Union or Local #* _____ *Work Phone* _____

Address of Employer _____ *City* _____ *State* _____ *Zip* _____

Insurance Company _____ *Group #* _____ *Policy/ID #* _____

Ins. Co. Address _____ *City* _____ *State* _____ *Zip* _____

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? ☐ *Yes* ☐ *No* *IF YES, COMPLETE THE FOLLOWING:*

Name of Insured _____ *Relationship to Patient* _____

Birthdate _____ *SS# / ID#* _____ *Date Employed* _____

Name of Employer _____ *Union or Local #* _____ *Work Phone* _____

Address of Employer _____ *City* _____ *State* _____ *Zip* _____

Insurance Company _____ *Group #* _____ *Policy/ID #* _____

Ins. Co. Address _____ *City* _____ *State* _____ *Zip* _____

Over Please

Patient Medical History

(CONFIDENTIAL)

Are you under a medical treatment now? ○ Yes ○ No If yes _____

Have you ever been hospitalized or had a major operation? ○ Yes ○ No If yes _____

Have you ever had a serious head or neck injury? ○ Yes ○ No If yes _____

Are you taking any medications, pills, or drugs? ○ Yes ○ No If yes _____

Do you take, or have taken, Phen-Fen or Redux? ○ Yes ○ No If yes _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ○ Yes ○ No If yes _____

Are you on a special diet? ○ Yes ○ No

Do you use tobacco? ○ Yes ○ No

Women: Are you.....

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Any other allergies? ○ Yes ○ No If yes _____

Do you use controlled substances? ○ Yes ○ No If yes _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	○ Yes ○ No	Cortisone Medicine	○ Yes ○ No	Hemophilia	○ Yes ○ No	Radiation Treatments	○
Alzheimer's Disease	○ Yes ○ No	Diabetes	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Anaphylaxis	○
Drug Addiction	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No	Renal Dialysis	○ Yes ○ No	Anemia	○
Easily Winded	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No	Angina	○ Yes ○ No	Emphysema	○
High Blood Pressure	○ Yes ○ No	Rheumatism	○ Yes ○ No	Arthritis/Gout	○ Yes ○ No	Epilepsy or Seizures	○
High Cholesterol	○ Yes ○ No	Scarlet Fever	○ Yes ○ No	Artificial Heart Valve	○ Yes ○ No	Excessive Bleeding	○
Hives or Rash	○ Yes ○ No	Shingles	○ Yes ○ No	Artificial Joint	○ Yes ○ No	Excessive Thirst	○
Hypoglycemia	○ Yes ○ No	Asthma	○ Yes ○ No	Fainting Spells/ Dizziness	○ Yes ○ No	Irregular Heartbeat	○
Sinus Trouble	○ Yes ○ No	Blood Disease	○ Yes ○ No	Frequent Cough	○ Yes ○ No	Kidney Problems	○
Blood Transfusion	○ Yes ○ No	Leukemia	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No	Breathing Problems	○
Frequent Headaches	○ Yes ○ No	Liver Disease	○ Yes ○ No	Stroke	○ Yes ○ No	Bruise Easily	○
Genital Herpes	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No	Swelling of Limbs	○ Yes ○ No	Cancer	○
Lung Disease	○ Yes ○ No	Thyroid Disease	○ Yes ○ No	Chemotherapy	○ Yes ○ No	Hay Fever	○
Mitral Valve Prolapse	○ Yes ○ No	Tonsillitis	○ Yes ○ No	Chest Pains	○ Yes ○ No	Heart Attack/Failure	○
Osteoporosis	○ Yes ○ No	Tuberculosis	○ Yes ○ No	Cold Sores/Fever Blisters	○ Yes ○ No	Heart Murmur	○
Pain in Jaw Joints	○ Yes ○ No	Tumors or Growths	○ Yes ○ No	Congenital Heart Disorder	○ Yes ○ No	Heart Pacemaker	○
Parathyroid Disease	○ Yes ○ No	Ulcers	○ Yes ○ No	Convulsions	○ Yes ○ No	Heart Trouble/ Disease	○
Psychiatric Care	○ Yes ○ No	Venereal Disease	○ Yes ○ No	Yellow Jaundice	○ Yes ○ No		

Have you ever had any serious illness not listed? ○ Yes ○ No If yes _____

Patient Dental History

Name of Previous General Dentist and Location _____ *Date of Last Exam* _____

Have you ever seen an ☐ *Endodontist* ☐ *Periodontist* ☐ *Oral Surgeon*

	Yes	No
1. *Do your gums bleed while brushing or flossing?*	☐	☐
2. *Are your teeth sensitive to hot or cold liquids/foods?*	☐	☐
3. *Are your teeth sensitive to sweet or sour liquids/foods?*	☐	☐
4. *Do you feel pain to any of your teeth?*	☐	☐
5. *Do you have any sores or lumps in or near your mouth?*	☐	☐
6. *Have you had any head, neck or jaw injuries?*	☐	☐
7. *Have you ever experienced any of the following problems in your jaw?*		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

8. *Do you have frequent headaches?* .....
9. *Do you clench or grind your teeth?* .....
10. *Have you ever had any difficult extractions in the past?* .....
11. *Are you on Coumadin or other blood thinning agents?* .....
12. *Have you had any orthodontic treatment?* .....
13. *Do you wear dentures or partials?* .....
    If yes, date of placement _____
14. *Have you ever received oral hygiene instructions regarding the care of your teeth and gums?* .....
15. *Do you like your smile?* .....

Authorization and Release

Payment is due in full at the time of treatment *unless prior arrangements have been approved.*
This office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payme deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis records of treatment or examination rendered, to my insurance company.
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 he 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 necessary dental services that I may need during diagnosis and treatment, with my informed consent.

X _____

Signature of patient (or parent/guardian if minor) *Date*