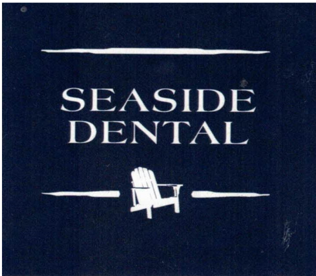

Drs. Lange, Minger, & Kim

We look forward to having you join our great family of friends and patients. The benefits of a health, beautiful smile are immeasurable. Our goal is to allow you to obtain the healthy teeth and attractive smile you want and deserve. Please complete this form so we may provide the best possible care for you.

Mr. Mrs. Ms. Dr.____Date__________
First Middle Last

Preferred Name________________________________

Patient's Birthdate ______________________________Social Security Number_____-__-_____

Child_____Single_____Married_____Separated_____Widowed_____Divorced _____

Mailing Address____
Street City State Zip

Home Telephone____________________Work Telephone__________________Pager/Cell Ph.____________________
Optional

Patient's Occupation_______________________________ E Mail ______________________________________
Patient's Employer/School________________________________

Spouse's or Guardian's Name____
First Middle Last

Spouse's or Guardian's Birthdates___________Social Security Number____-___-____Spouse's or Guardian's Occupation_________

Spouse's or Guardian's Employer____________________Work Telephone_________________

Dental Insurance Information

Insurance Company______________________Phone Number_________________________

Insured's Name_________________________ DOB_________ ID#_____________________Group#__________

In case of an Emergency, please contact____

Home Phone____Work/Cell Phone _______________________

*Whom may we thank for recommending you to our office?*____

Name of Person responsible for this account?____

I. CIRCLE APPROPRIATE ANSWER (leave Blank if you do not understand question):

1. Yes No Is your general health good?
2. Yes No Has there been a change in your health within the last year?
3. Yes No Are you being treated by a physician now? For what?______________________________

Date of last medical exam?__________________Date of last Dental exam?__________________

4. Yes No Have you ever had a serious head or neck injury?
5. Yes No Are you on a special diet?
6. Yes No Have you been hospitalized or had a serious illness in the past three years? If YES why?____________________
7. Yes No Have you had problems with prior dental treatment?______________________________
8. Yes No Are you in pain now?______________________________

II. HAVE YOU EXPERIENCED:

9. Yes No Chest pain (angina)?
10. Yes No Swollen ankles?
11. Yes No Shortness of breath?
12. Yes No Recent weight loss, fever, night sweats?
13. Yes No Persistent cough, coughing up blood?
14. Yes No Bleeding problems, bruising easily?
15. Yes No Sinus problems?
16. Yes No Difficulty swallowing?
17. Yes No Diarrhea, constipation, blood in stools?
18. Yes No Frequent vomiting, nausea?
19. Yes No Difficulty urinating, blood in urine?
20. Yes No Dizziness?
21. Yes No Ringing in ears?
22. Yes No Headaches?
23. Yes No Fainting spells?
24. Yes No Blurred vision?
25. Yes No Seizures?
26. Yes No Excessive thirst?
27. Yes No Frequent urination?
28. Yes No Dry mouth?
29. Yes No Jaundice?
30. Yes No Joint pain,

III. DO YOU HAVE OR HAVE YOU HAD:

31. Yes No Heart disease?
32. Yes No Heart attack, heart defects?
33. Yes No Heart murmurs?
34. Yes No Rheumatic fever?
35. Yes No Stroke, hardening of arteries?
36. Yes No High blood pressure?
37. Yes No Asthma, TB, emphysema, other lung diseases?
38. Yes No Hepatitis, other liver disease?
39. Yes No Stomach problems, ulcers?
40. Yes No Allergies to: drugs, foods, medications, latex?
41. Yes No Family history of diabetes, heart problems, tumors?
42. Yes No HIV Virus or AIDS
43. Yes No Tumors, cancer?
44. Yes No Arthritis, rheumatism?
45. Yes No Eye diseases?
46. Yes No Skin diseases?
47. Yes No Anemia?
48. Yes No STD
49. Yes No Herpes?
50. Yes No Kidney, bladder disease?
51. Yes No Thyroid, adrenal
52. Yes No Diabetes?

Please list any other allergies: ______________________________

V. ARE YOU TAKING:

53. Yes No Recreational Drugs?
54. Yes No Do you use controlled substances?
55. Yes No Tobacco in any form?
56. Yes No Alcohol?
57. Yes No Bisphosphonate, Prolia?
58. Yes No Do you take, or have you taken, Phen-Fen or Redux?
59. Yes No Are you taking any medication, pills or prescription drugs?

Please list all medicine, drugs, pills, over-the-counter medications you are taking: ______________________________

____

IV. DO YOU HAVE OR HAVE YOU HAD:

61. Yes No Psychiatric care?
62. Yes No Radiation treatments?
63. Yes No Chemotherapy?
64. Yes No Prosthetic heart valve?
65. Yes No Artificial joint?
66. Yes No Hospitalization?
67. Yes No Blood transfusions?
68. Yes No Contacts?
69. Yes No Pacemaker?
70. Yes No Surgeries? If YES please explain:________________

VI. Dental History:

Reason for today's visit?____

Former Dentist________________________________ City/State________________________

Date of last dental visit________________________________ Date of last dental x-rays________________________

71. Yes No Bad Breath?
72. Yes No Bleeding Gums?
73. Yes No Blisters on lips or mouth?
74. Yes No Chew on one side of mouth?
75. Yes No Cigarette, pipe or cigar smoking?
76. Yes No Clicking or popping jaw?
77. Yes No Dry Mouth?
78. Yes No Fingernail biting?
79. Yes No Food Collection between teeth?
80. Yes No Grinding of teeth?
81. Yes No Gums swollen or tender?
82. Yes No Jaw pain or discomfort?
83. Yes No Loose teeth or broken filling?
84. Yes No Mouth Breathing?
85. Yes No History of orthodontic treatment?
86. Yes No History of root canal treatment?
87. Yes No History of periodontal treatment?
88. Yes No Sensitivity to cold, hot, sweets, biting?
89. Yes No Are you happy with your smile?
90. Yes No Have you ever had cosmetic dentistry

Yes No Is there anything you would like to change about your smile? If so what?________________________

____

VII. WOMEN ONLY:

91. Yes No Are you or could you be pregnant or nursing?
92. Yes No Are you taking birth control pills?

VIII. ALL PATIENTS:

93. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?

If so, please explain: ____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I also authorize to have photographs of my face, jaws and teeth taken. I understand that these items will be used as a record of my care, and may be used for educational purposes. I further understand that if these items are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

Patient's signature:______________________________ Date:__________________________