Welcome

TO FERGUSON
DENTAL ASSOCIATES

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us- we will be happy to help.

Patient # _____
SS#/SIN _____
Date _____

Patient Information (Confidential)

Name _____ Birthdate _____ Age _____ Home Phone _____
Address _____ City _____ State _____ Zip _____
E-mail _____ Cell Phone _____
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Patient or Parent/Guardian's Employer _____ Work Phone _____
Business Address _____ City _____ State _____ Zip _____
Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____
If Student, Name of School _____ City _____ State _____ ☐Full Time ☐Part Time
Whom May We Thank for Referring You? _____
Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____
Address _____ Home Phone _____
E-mail _____ 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. Payment is expected in full at each appointment.
☐ Cash ☐ Personal Check ☐Credit Card ☐ I wish to discuss the office's payment policy.

Insurance Information

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS#/SIN _____ 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 _____
How Much is your Deductible? _____ Max. Annual Benefit _____

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

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS#/SIN _____ 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 _____
How Much is your Deductible? _____ Max. Annual Benefit _____

Patient Dental History

Reason for this visit today _____ *Date of Last Dental Exam* _____

- *Do your gums bleed while brushing or flossing?* ☐ No ☐ Yes
- *Are your teeth sensitive to hot or cold liquids/foods?* ☐ No ☐ Yes
- *Are your teeth sensitive to sweet or sour liquids/foods?* ☐ No ☐ Yes
- *Do you feel pain to any of your teeth?* ☐ No ☐ Yes
- *Do you have any sores or lumps in or near your mouth?* ☐ No ☐ Yes
- *Have you had any head, neck, or jaw injuries?* ☐ No ☐ Yes
- *Have you ever experienced any of the following problems in your jaw?*
  - *Clicking?* ☐ No ☐ Yes
  - *Pain (joint, ear, side of face)?* ☐ No ☐ Yes
  - *Difficulty in opening, closing, or chewing?* ☐ No ☐ Yes
- *Do you clench or grind your teeth?* ☐ No ☐ Yes
- *Have you ever had any difficult extractions in the past?* ☐ No ☐ Yes
- *Have you ever had any prolonged bleeding after extractions?* ☐ No ☐ Yes
- *Have you had any orthodontic treatment?* ☐ No ☐ Yes
- *Do you wear dentures or partials?* ☐ No ☐ Yes
  If yes, date of placement _____
- *Have you ever received periodontal/gum treatment?* ☐ No ☐ Yes
- *Do you like your smile?* ☐ No ☐ Yes

Patient Health History

Date of last health care exam: _____ *What was this exam for?* _____
Have you been hospitalized in the last 5 years? ☐ No ☐ Yes
If yes, reason: _____
Are you currently receiving care? ☐ No ☐ Yes *If yes, nature of care:* _____
Please list all the names and phone numbers of the physicians who are currently providing you care:

1. _____
2. _____

Please list any medications you are currently taking and dosages:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Please list any dietary or herbal supplements you are taking, and for what purpose:

1. _____ 2. _____
3. _____ 4. _____

Women: Are you pregnant? ☐ No ☐ Yes
If no, are you planning a pregnancy in the near future? ☐ No ☐ Yes
Are you a nursing mother? ☐ No ☐ Yes
Are you taking any form of birth control? ☐ No ☐ Yes

Have you ever received a diagnosis of "high blood pressure"? ☐ No ☐ Yes
What is your normal blood pressure? _____ *Today:* _____

Are you allergic or have you had a reaction to:

a. *Local anesthetics* ..... ☐ No ☐ Yes
b. *Penicillin or other antibiotics* ..... ☐ No ☐ Yes
c. *Aspirin, Ibuprofen or Tylenol* ..... ☐ No ☐ Yes
d. *Codeine, Valium® or other sedatives* ..... ☐ No ☐ Yes
e. *Latex or Metals* ..... ☐ No ☐ Yes
f. *Other (please specify)* _____

For the following questions indicate yes or no. Your answers are for our records only and will be confidential.

Anemia or Blood Disorder?	☐No	☐Yes	*Hepatitis, Any Form?*	☐No	☐Yes
Arthritis, Rheumatism or other inflammatory disease?	☐No	☐Yes	*Joint Replacement? When placed?*	☐No	☐Yes
Asthma?	☐No	☐Yes	*Kidney Disease?*	☐No	☐Yes
Abnormal Bleeding from a cut?	☐No	☐Yes	*Liver Disease (including Jaundice)?*	☐No	☐Yes
Cancer or Tumor?	☐No	☐Yes	*Sore/Enlarged Lymph Nodes?*	☐No	☐Yes
Diabetes or circulatory problems?	☐No	☐Yes	*Psychosis?*	☐No	☐Yes
Emphysema or other Respiratory/Lung Illnesses?	☐No	☐Yes			
Back Problems?	☐No	☐Yes	*Previous Biopsies?*	☐No	☐Yes
Epilepsy?	☐No	☐Yes	*Radiation or Chemotherapy Treatment?*	☐No	☐Yes
Fainting or Dizzy Spells?	☐No	☐Yes	*Rheumatic Fever?*	☐No	☐Yes
Glaucoma?	☐No	☐Yes	*Slow-Healing Mouth Sores?*	☐No	☐Yes
Abnormal Heart or Previous Bacterial Endocarditis?	☐No	☐Yes	*Unintentional Weight Loss/Gain?*	☐No	☐Yes
Heart Valve (artificial) or Heart Transplant?	☐No	☐Yes	*H.I.V. Infection/AIDS?*	☐No	☐Yes
Congenital Heart Disease?	☐No	☐Yes	*Venereal Disease?*	☐No	☐Yes
Heart Disease, Heart Attack, Heart Surgery?	☐No	☐Yes	*Other Conditions?*	☐No	☐Yes
Heart Stent? When placed?	☐No	☐Yes	*Recurrent Illnesses?*	☐No	☐Yes

Are you taking any of these medications?

Pre-medication before dental treatment?	☐No	☐Yes	*Tagamet® (cimetidine) or Prilosec® (omeprazole)?*	☐No	☐Yes
Antacids?	☐No	☐Yes	*Cardizem® (diltiazem) or Calan, Isoptin® (Verapamil)?*	☐No	☐Yes
Dilantin® or Tegretol®	☐No	☐Yes	*Serzone® (nefazodone)*	☐No	☐Yes
Barbiturates (any)	☐No	☐Yes	*Diflucan® (fluconazole) or Sporonox® (itraconazole)*	☐No	☐Yes
St. John's Wort or Kava-Kava?	☐No	☐Yes	*Biaxin® (clarithromycin)*	☐No	☐Yes

Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®)? ☐No ☐Yes
If so, when did the treatment begin? *When did the treatment end?*
Have you ever taken any prescription drugs such as fen-phen for weight loss? ☐No ☐Yes
Do you consume grapefruit juice, grapefruits or grapefruit extract? ☐No ☐Yes

Tobacco, Alcohol, Drugs

Do you use tobacco? If yes, circle type: smoke chew How much per day?	☐No	☐Yes
Do you want to quit using tobacco?	☐No	☐Yes
Do you consume alcohol? If yes, approximately how many alcoholic beverages per week?	☐No	☐Yes
Do you use any mood altering drugs other than those previously listed?	☐No	☐Yes

Authorization and Release

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 me or my child 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.

Patient (Print Name)	*Patient Signature*	*Date*
Doctor (Print Name)	*Doctor Signature*	*Date*

DOCTOR'S USE ONLY

Comments on patient interview concerning medical history:

Significant findings from questionnaire or oral interview:

Dental management considerations: