Doctors Paul Davis, Lauren Drennan (formerly Davis), and Dakota Davis
Our Family Caring for Yours

Patient Information

Patient's Name _____ Date_____/_____/_____
Last First Middle
Address_____
Street City State Zip
Home Phone _____ Work Phone _____ Cell Phone _____
Birth Date___/___/____ Social Security # _____
Email Address _____ May we contact you by email? □Yes □ No
Employer _____ Occupation _____ # Years Employed_____
Responsible party's name: _____ Birth Date____/____/____
Relationship to patient _____ Occupation _____ Social Security # _____
Address_____
Street City State Zip
How did you hear about us? □Friend/Family _____ □Internet □Drive-by □Other: _____

Insurance Information

Insured's Name_____
Insured's Birth Date_____/_____/_____ Insured's Soc Sec # _____
Insurance Company _____ Group # _____ ID # _____
Insurance Co. Address _____Phone # _____

Spouse Information

Spouse's Name _____Relationship to Patient _____
Employer_____ Occupation_____No. Years Employed_____
Social Security # _____ Birth Date_____ Work Phone_____

Emergency Information

Name of nearest relative not living with you _____
Address_____
Street City State Zip
Contact phone # _____ Relationship _____

Visit our website DavisFamilyDentists.com for detailed information and videos of our procedures.

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Patient Name:_____

Medical History

Are you currently under the care of a physician? □Yes □ No Date of last physical: _____
Physican's name: _____ Phone # _____ Your physical health is: Good Fair Poor
Do you smoke or use tobacco in any form? □Yes □ No If yes, please explain:_____

Have you ever had any of the following diseases or medical problems?

Y N Anemia/Hemophilia/Abnormal Bleeding
Y N Blood Transfusions
Y N Artificial Bones/Joints
Y N Arthritis
Y N Osteoporosis
Y N Heart Attack/Disease: if yes, when?_____
Y N Heart Surgery/Pacemaker: if yes, when?_____
Y N Artificial Valves
Y N Congenital Heart Defect/Murmur
Y N Mitral Valve Prolapse
Y N High Blood Pressure
Y N Low Blood Pressure
Y N Difficulty Breathing
Y N Asthma
Y N Emphysema
Y N Tuberculosis (TB): if yes, when?_____
Y N Chronic Bronchitis/COPD
Y N Sinus Problems
Y N Cancer/Radiation/Chemotherapy
Y N Depression/Anxiety
Y N Mental Disorders
Y N Epilepsy/Seizures/Fainting Spells
Y N Alcohol Dependency
Y N Drug Dependency: if yes, explain_____
Y N Insulin-Dependent Diabetes
Y N Type 2 Diabetes
Y N Glaucoma
Y N Fever Blisters/Herpes
Y N Hepatitis. Please circle which type: A B C
Y N HIV +/AIDS
Y N Shingles
Y N Kidney Problems
Y N Severe/Frequent Headaches
Y N Stroke/TIA
Y N Thyroid Problems
Y N Ulcers/Colitis
Y N Do you need premedication? Condition_____
Y N Hospitalized for Any Reason: explain_____

Have you ever taken a bone metabolism (**osteoporosis**) medication such as: Boniva, Fosamax, Zometa, Aredia, Actonel, etc.? If yes, please list which medication and how long: _____

Please list any **drugs/medications** that you are currently taking:

_____
_____
_____
_____

Are you **allergic** to any of the following?
Y N Aspirin
Y N Dental Anesthetics
Y N Latex
Y N Tetracycline
Y N Codeine
Y N Erythromycin
Y N Penicillin
Y N Sulfa or Sulfur Drugs
Y N Nickel
Y N Other
Please list any other drugs/medications that you are **allergic** to:

_____
_____
_____

For Women
Y N Are you pregnant or do you think you could be pregnant? Months: _____
Y N Are you nursing?
Y N Are you taking birth control prescriptions?

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Davis
Family Dental Care

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Dental History

General Dental

How can we help you today? _____
Is there anything about your mouth that concerns you now? _____
Do you experience discomfort when biting or chewing?_____
Do you experience sensitivity to hot or cold?_____
Do you have any old fillings or dental work that you do not like? _____
Do you still have your wisdom teeth? _____
Do you have any missing teeth? _____
When was the last time you visited the dentist? _____
When was the last time you had x-rays? _____

Your Dental Care Practices

How many times a day do you brush? _____ Floss?_____
What type of toothbrush do you use? (Circle one) Manual Electric Hard Medium Soft Other: _____
Do your gums bleed?_____ If yes, when? _____
Have you ever been diagnosed with gum disease, had gum treatment, or a deep cleaning? _____
Would you like us to coach you on home care? _____

Esthetics and Orthodontics

Are you pleased with the appearance of your teeth? If not, what do you not like? _____
Do you have any chipped teeth? _____
Are you happy with the color and shape of your teeth? _____
Have you ever had orthodontics?_____Are you pleased with the result? _____

Joint Symptoms

Do you experience popping, clicking, pain, or discomfort in your jaw joint area? _____
Do you wake up with a headache or jaw ache? _____
Are you aware of grinding or clenching? _____
Do you have a bite splint? _____ Do you wear it?_____
Has your bite been equilibrated? _____

Values and Expectations

What is/was the health of your parents' teeth?_____
Would you like to keep your teeth for a lifetime? Circle one: **Definitely want to Would be nice Only if it is affordable**
Do you have a high sugar or carbohydrate diet? _____
Any habits we should be aware of? Nail biting, toothpicks, mints or hard candy, other _____
Are you nervous about having dental treatment? _____
Is there anything we can do to make your visits more pleasant? _____

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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 held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.
Please initial after reading each of the following:

— I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to Third Party Payor.

— I authorize and hereby request my insurance company to pay directly to the dentist (or the dental group) insurance benefits otherwise payable to me.

— **I understand that due to the restrictions placed by my insurance company on the level of benefits in the policy purchased by me/my employer, MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR THE SERVICES. I agree to be responsible for payment of all services rendered on my behalf or on the behalf of my dependents.**

— **All patients with Delta Dental Insurance must pay in FULL for treatment at the time of service and will be reimbursed by their insurance company.**

Signature (Parent or Guardian's signature if minor)_____

Printed Name_____