HOMER DENTAL CENTER, INC.

4014 Lake Street, Suite 210 Homer, AK 99603 907 235-7585

Welcome to our Dental Office. We appreciate your selection and look forward to getting to know you. If you have any questions, please do not hesitate to ask for assistance.

PATIENT INFORMATION

Name _____
Address _____
City _____State___Zip_____
Residence Physical Address
_____
Birth date_____Age_____Sex___M_____F
__Single__Married__Divorced__Separated__Widow
Spouse_____Birth date_____
Children/Ages_____
_____
Phone_____Wk_____Cell_____
Best Daytime Number to contact _____
Emergency Contact _____
Phone _____Relationship_____
Hobbies/Special Interest_____
Email :_____

RESPONSIBLE PARTY

Relationship to Patient _____
Name _____
Address _____
City _____State_____ Zip_____
Phone _____Wk_____ Cell_____
Employer _____ Phone_____
Occupation _____How Long_____
Spouse _____Birth date_____
Employer_____Phone_____
Dental Insurance- Subscriber _____
ID#_____Birth date_____
Group #_____Phone_____
Company _____Employer_____
City_____State_____Zip_____
Deductible_____ Met_____Annual Benefit_____

DENTAL HISTORY

Reason for todayôs visit _____Former Dentist _____City_____State____
Date of last dental visit_____Date of last dental x-rays_____Pano Film_____
How often do you brush? _____ Floss _____ Fluoride Rinse _____
Do you Smoke?_____Have you ever?_____ How long?_____ How many each day?_____Chew Tobacco____
Please indicate if you have had any of the following conditions:

___Bad Breath	___Grinding Teeth/Bruxism	___Mouth Breathing
___Bleeding Gums	___Gums Swollen or Tender	___Orthodontic Treatment
___Blisters on Lip/Mouth	___Jaw Pain	___Periodontal Treatment
___Clicking or Popping Jaw	___Latex Allergy	___Pressure when biting
___Dry Mouth	___Lip or Cheek Biting	___Sensitive to Hot/Cold
___Food Collects between teeth	___Loose Teeth/Broken Fillings	___Sensitive to Sweet

Have you had any serious trouble with previous dental treatment? _____
Have you ever had a local anesthetic? (Novocaine, etc.)_____Any reaction?_____
Have you ever been pre-medicated with antibiotics for dental treatment? _____
Medication and dosage_____
Does dental treatment make you nervous? _____ How Much? ____ Slightly ___ Moderately____ Extremely
Would you desire to be pre-sedated?_____ Have you used Nitrous Oxide before? _____

MEDICAL HISTORY

Physicianôs Name _____Date of Last Visit _____
Please list all medications you are currently taking:_____
_____
Do you use recreational drugs? (Marijuana, cocaine, etc.)_____How often?_____
Amphetamine or cocaine use prior to administration of local anesthetic for dental treatment can induce life threatening medical emergencies.
Allergies:_____
Have you ever had a serious illness or operation? ____Explain_____
Do you have or have you had any of the following:

___Anemia/Hemophilia	___Cortisone Treatments	___High Blood Pressure	___Shortness of Breath
___Anxiety/Nervous	___Cough, Persistent	___HIV/AIDS	___Sinus Problems
___Arthritis/Rheumatism	___ Diabetes	___Jaw Pain/TMJ	___Skin Rash
___Artificial Heart Valves	___Epilepsy/Seizure	___Kidney Disease	___STD
___Artificial Joints	___Fainting/Dizzy Spells	___Liver Disease	___Stroke
___Asthma/Emphysema	___Fever Blisters/Herpes	___Leukemia	___Swelling of Feet/Ankle
___Back Problems	___Glaucoma	___Mitral Valve Prolapse	___Thyroid Problems
___Blood Disease	___Hay Fever/Allergies	___Pacemaker	___Tonsillitis
___Blood Transfusion	___Headaches	___Psychiatric Care	___Tuberculosis
___Cancer_____	___Heart Murmur	___Radiation Treatment	___Ulcer
___Chemical Dependency	___Heart Problems	___Respiratory Disease	
___Chemotherapy	type-_____	___Rheumatic Fever	
___Circulatory Problems	___Hepatitis/Jaundice	___Scarlet Fever	

Women: Are you pregnant?____Nursing____ Birth Control Pills _____Menopause_____Hormone Therapy_____
Do you have any disease, condition or problem not listed that I should be aware of?____Describe_____
_____

Authorization

I certify that to the best of my knowledge, the above answers are true and correct. I understand that providing incorrect information can be dangerous to my health. If there are any changes in my health or medications, I will inform the Dentist at next appointment. I authorize the dentist to release any information including the records of treatment given to my insurance company or other health care providers. I understand that I am responsible for the payment of all services performed for my or my dependents.

Signature of Patient_____Date_____

Updates (to be completed at future appointments)
Changes in Health_____
New Medications_____
Signature_____Date_____

Changes in Health_____
New Medications_____
Signature_____Date_____

Changes in Health_____
New Medications_____
Signature_____Date_____