Renton Denture Clinic

Name		Hm Phone
Address		Email
City State Zip		Cell Phone
ε M ε F	ε Single ε Married	Date of Birth ____/_____/____AGE __________
Which contact phone number / email do you prefer	Home / Cell / Work / Email	
Employer	SS # ________-______-________	
Employers Phone	Is it okay to contact you at work? Y / N	
Who may we thank for referring you?		
Emergency Contact: Name		Phone

Primary Insurance	**Secondary Insurance**
Insurance Company ______________________________	Insurance Company ______________________________
Name of Insured ______________________________	Name of Insured ______________________________
Relationship to Patient ______________________________	Relationship to Patient ______________________________
Subscriber's Name ______________________________	Subscriber's Name ______________________________
Subscriber's SS# ________-________-________	Subscriber's SS# ________-________-________
Subscriber's DOB ________/________/________	Subscriber's DOB ________/________/________

DENTAL HISTORY

Reason for today's visit: ______________________________________Former Dentist:______________________________

Check any that apply:
- ε Periodontal Treatment
- ε Orthodontic Treatment
- ε Loose teeth/Broken fillings
- ε Dry Mouth
- ε Jaw Pain
- ε Clicking/Popping jaw

Do you wear dentures or partials? Y N

ε Upper Denture / Partial
ε Age of appliance________

ε Lower Denture / Partial
ε Age of appliance_________

RESPONSIBILITIES AND RELEASE

I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the doctor to release all information necessary to secure payment of benefits.

I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance may pay less than the actual bill for services. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature ____ Date ________________

Relationship to Patient____

HEALTH HISTORY

Physicians Name ______________________________________ Date of last visit:________________________

Please check any that apply

- ε Diabetes
- ε Thyroid Problems
- ε Shortness of Breath
- ε Asthma
- ε COPD (Emphysema, Bronchitis)
- ε TB
- ε Heart Murmur
- ε Rheumatic Fever
- ε High Blood Pressure
- ε Angina/Chest Pain
- ε Heart Attack
- ε Pacemaker
- ε Stroke
- ε Other Heart Problems
- ε Bleeding Disorder/Abnormal Bleeding
- ε Autoimmune Disorder
- ε Head Aches
- ε Jaw Pain
- ε Gastrointestinal Problems/Ulcers/Reflux
- ε Kidney Problems
- ε Liver Problems
- ε Hepatitis Type:________
- ε Jaundice
- ε Cancer (radiation/chemotherapy)
- ε Skin/Muscle/Bone Problems
- ε Nervous Problems
- ε Seizures
- ε Blood Transfusions
- ε Smoker How many per day ___________
- ε Alcohol How many drinks per week _________
- ε Recreational Drug Use
- ε STD / HIV / AIDS
- ε Trauma
- ε Surgeries/Hospitalizations________________________

____

____

Women:
Are you pregnant? Y N Due Date:______________________ Are you nursing? Y N

MEDICATIONS
List any medications you are currently taking:

____

____

____

____

ALLERGIES
List any allergies you have including to medications:

____

____

____

____

DOCTOR USE ONLY

UPDATES

Have there been changes in health since last visit? Y N

____

____

New Medications:___________________________________

____

____

MODIFICATIONS TO TREATMENT

Anesthetic: ____________________________________

N2O: ____

PreMed: _______________________________________

Other: ____

____

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(Please note date of update)