Welcome to Belpre Dental Studio

Please take a few minutes to fill out this form as completely as you can. If you have questions, we are happy to help.
We look forward to helping you optimize your dental health.

Patient Information

Name_____ ☐ Male ☐ Female
Last First Middle Initial

☐ Married ☐ Single ☐ Other Birthdate_____ Social Security # _____

Address_____
Street City State Zip

Email_____ Home Phone _____ Work Phone _____

Cell Phone_____ Preferred Contact Method: ☐ Text ☐ Email ☐ Call

Emergency Contact_____
Name Home Phone Cell Phone

Employer_____
Name Address Phone

Primary Insurance

Insurance Company _____
Name Address Phone

Member ID_____ Subscriber _____
Name Birthdate Social Security #

Group #_____ Patient's Relationship to Subscriber _____

Secondary Insurance

Insurance Company _____
Name Address Phone

Member ID_____ Subscriber _____
Name Birthdate Social Security #

Group #_____ Patient's Relationship to Subscriber: _____

Dental History

Former Dentist _____
Name Address Phone

Why have you come to the dentist today?_____

☐ Yes ☐ No Has your doctor ever advised you to pre-medicated before dental treatment? Reason_____
☐ Yes ☐ No Have you ever had a serious/difficult problem associated with any previous dental work?
☐ Yes ☐ No Do you now or have you ever experienced pain or discomfort in your jaw joint (TMJ/TMD)?
☐ Yes ☐ No Would you like whiter teeth?
☐ Yes ☐ No Do you smoke or use tobacco in any form? If so how much per day? _____ How long have you smoked?_____
☐ Yes ☐ No Is there anything you have ever wished was different about your teeth, mouth or smile?

See Other Side

Medical History

Primary Physician_____
Name Address Phone

Other Physician_____
Name Address Phone

Pharmacy Name_____ Phone_____

Date of last exams: **Dental**_____ **Medical**_____ What was exam for?_____ Are you currently receiving care?_____

If yes, what type of care?_____Have you been hospitalized in the last 5 years?_____ If yes, what was the reason?_____

☐ Yes ☐ No Have you ever taken bisphosphonate to treat osteoporosis or cancer? (Fosamax, Actonat, Boniva, Reclast, Zometa, Aredia, Prolia, Xgeva)

☐ Yes ☐ No Are you taking Tagamet/ Cimetidine? If yes, how often?_____

☐ Yes ☐ No Are you taking any Antacids?

For Women:

☐ Yes ☐ No Are you pregnant? If yes, week #___

☐ Yes ☐ No Are you using prescription birth control?

☐ Yes ☐ No Are you nursing?

Please mark if you have or have ever had any of the following conditions:

☐ Alcohol/Drug Abuse
☐ Arthritis
☐ Asthma
☐ Bone/Joint/Valve Replacement
Area & date of replacement_____
☐ Cancer/Chemotherapy
☐ Congenital Heart Defect
☐ Emphysema
☐ Excessive/Abnormal Bleeding
☐ Fainting Spells
☐ Frequent Headaches
☐ Glaucoma
☐ Heart Attack
☐ Heart Murmur
☐ Other _____

☐ Heart Surgery
☐ Hepatitis, any form
☐ COPD/ Respiratory Disease
☐ HIV/AIDS
☐ Kidney Problems or Disease
☐ Liver Disease
☐ Osteoporosis/Osteopenia
☐ Pacemaker
☐ Radiation Treatment
☐ Seizures
☐ Sinus Problems
☐ Thyroid Problems
☐ TMJ Pain
☐ Tuberculosis
☐ Migranes
☐ Congestive Heart Failure

☐ Diabetes
HgA1C:_____ Date last checked_____
☐ High Blood Pressure
Usual S_____/D_____
☐ Low Blood Pressure
Usual S_____/D_____
☐ Previous Biopsies
☐ Snoring or Sleep Apnea
☐ Use a CPAP
☐ Anemia
☐ Epilepsy
☐ Dry mouth
☐ Sore/ Enlarged Lymph Nodes
☐ Slow Healing Mouth Sores
☐ Sexually Transmitted Disease
☐ Coronary Artery Disease

Please mark if you are allergic to any of the following:

☐ Aspirin ☐ Anesthetics Explain:_____ ☐ Codeine ☐ Erythromycin ☐ Latex ☐ Penicillin ☐ Sulfa ☐ Tetracycline

☐ Advil/ Ibprofen ☐ Tylenol/ Acetaminophen ☐ Please list other (include drugs, medications, foods, seasonal, etc.)_____

Medications/ Herbal Supplements (or submit list to be copied): _____

_____

_____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

Signature_____ Date_____