Patient Information Form

Today's Date _____

Patient's Name First _____ MI ____ Last _____ Nickname _____

Address Street _____ City _____ State _____ Zip _____

Phone Primary _____ Mobile _____ Work _____

Date of Birth _____ **Social Security Number** _____

Drivers License # _____ State _____

Patient Employed By _____ Phone _____

Address Street _____ City _____ State _____ Zip _____

Sex ☐Male ☐Female **Marital Status** ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed

In case of emergencies, who should be notified? _____

Relationship to Patient _____ Primary Phone _____

Is patient a minor ☐Yes ☐No **Full Time Student** ☐Yes ☐No Name of School _____

Name of Responsible Party First _____ Last _____

Date of Birth _____ Relationship to Patient ☐Spouse ☐Parent ☐Other: _____

If Patient is a Minor, primary residence: ☐Both parents ☐Mom ☐Dad ☐Shared Custody ☐Guardian ☐Other: _____

Address (*if different from patient)* Street _____ City _____ State _____ Zip _____

Phone Primary _____ Mobile _____ Work _____

Employer *(if different from above)* _____ Phone _____

Address Street _____ City _____ State _____ Zip _____

Dental Insurance Information

Primary Dental Plan Name _____ **Phone** _____

Address Street _____ City _____ State _____ Zip _____

Name of Insured _____ **Date of Birth** _____ ID # _____

Policy Number _____ **Patient Relationship to Insured** _____

Secondary Dental Plan Name _____ **Phone** _____

Address Street _____ City _____ State _____ Zip _____

Name of Insured _____ **Date of Birth** _____ ID # _____

Policy Number _____ **Patient Relationship to Insured** _____

How did you hear about us?

☐One of our valued patients (name of patient) _____

☐Facebook ☐Our Website

☐Phonebook ☐Internet Search

☐Our Location ☐Other: _____

Dental History Form

What are your goals in coming to our practice today? _____

What is important to you in a dentist or dental practice? _____

Date of last radiographs (xrays) and exam _____

Date of last hygiene continuing care appointment *(cleaning or periodontal maintenance)* _____

Former Dentist _____ Phone _____

If you left your previous dentist, what are the reasons? _____

Have you had problems with prior dental treatment? ☐Yes ☐No

If yes, what were they? _____

Are you experiencing any pain now? ☐Yes ☐No

If yes, please describe _____

Have you ever been pre-medicated for dental treatment? ☐Yes ☐No

If yes, why? _____

Have you been anxious about having dental treatment? ☐Yes ☐No

If yes, would you be comfortable sharing why? _____

Would you like to discuss this concern with the doctor to learn about your relaxation options? ☐Yes ☐No

What concerns do you currently have with your oral health or smile? *(please check all that apply)*

☐Jaw joint pain
☐Clenching or grinding of teeth
☐Discolored teeth
☐Crowding/crooked teeth
☐Missing teeth
☐Spaces in between teeth
☐Loose tooth/teeth
☐Tooth shape/size
☐Unhappy with appearance of teeth
☐Overbite
☐Underbite
☐Uncomfortable bite
☐Old fillings *(gold or silver)*
☐Old crowns
☐Speech problems
☐Too much gum tissue when I smile
☐Tooth sensitivity to hot/cold
☐Tooth sensitivity to biting
☐Tooth sensitivity to sweets
☐Food gets caught between teeth
☐Difficulty chewing
☐Bad breath
☐Other: _____

Have you ever had orthodontic treatment? ☐Yes ☐No If yes, when? _____

Have you ever had periodontal treatment such as deep cleanings, root planning, or periodontal surgery? ☐Yes ☐No

If yes, what kind of treatment and when? _____

Are you interested in learning about the following? *(please check all that apply)*

☐Teeth Whitening
☐Orthodontic treatment
☐Tooth replacement options
☐Botox for clenching and grinding
☐Tooth colored fillings
☐Dental implants
☐oral hygiene care for infants/toddlers
☐Cosmetic Botox
☐At home oral hygiene care
☐Periodontal prevention/treatment
☐Juvederm filler around mouth
☐Other: _____

Health History Form

Name of Physician _____ Phone _____

Have you been admitted to a hospital or needed emergency care during the past two years? ☐Yes ☐No

If yes, please explain _____

Do you have any allergies? ☐Yes ☐No

☐Penicillin ☐Latex ☐Other: _____

Are you currently taking any medications? ☐Yes ☐No

☐Blood thinner? If so, which kind? _____

If yes, please list all medications or provide a separate complete list _____

_____

_____

Have you ever had any of the following? *(please check all that apply)*

☐AIDS / HIV	☐Epilepsy	☐High blood pressure	☐ Pacemaker
☐Anemia	☐Excessive bleeding	☐Kidney disease	☐Pregnancy
☐Arthritis	☐Fainting	☐Liver disease	Due date: _____
☐Artificial joint / heart valve	☐Head injury	☐Mental disorder	☐Radiation treatment
Date: _____	☐Heart Attack / Surgery	☐Multiple sclerosis	☐Rheumatic fever
☐Asthma	Date: _____	☐Myasthenia gravis	☐Sinus problems
☐Blood disease	☐Heart murmur	☐Nervous disorder	☐Stroke
☐Cancer	☐Hepatitis	☐ Osteoporosis	Date: _____

Do you have any health problems that need further clarification? ☐Yes ☐No

If yes, please explain _____

_____

_____

Communication Preferences

What is your preferred method of communication? *(please check all that apply)*

☐ **Phone call** – best number to reach you: _____

☐ **Text message** – best number to text you: _____

☐ **Email** – please provide your email address: _____

Notice of Privacy Practice

☐ I acknowledge that I have received a copy of the South Roots Dental of Louisiana Notice of Privacy Practice to review.

Financial Policy

☐ I have read the Southern Roots Dental of Louisiana Financial Policy, and I understand and agree to this policy.

Signature of Patient or Responsible Party: _____ Date: _____