DeMers Dental
Welcome To Our Office

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Male ☐ Female

First Name ____ MI ____ Last Name ____ Preferred Name ____

Street Address ____ City ____ State ____ Zip ____

Social Security Number ____ Date of Birth ____ Home Phone ____ Daytime Phone ____

Email Address ____ Occupation ____ Spouse or Parent(s) Name ____

Person Financially Responsible, If Different From Above

Name ____ Phone ____ Social Security Number ____

Address ____ Date of Birth ____

For new patients, this information will be used for a credit check.

Dental History

Former Dentist's Name ____ City, State ____

My mouth is:
- ○ very comfortable
- ○ moderately comfortable
- ○ uncomfortable

I think I:
- ○ am in EXCELLENT oral health
- ○ am in GOOD oral health
- ○ am in POOR oral health

I desire:
- ○ excellent oral health
- ○ average or good oral health
- ○ crisis care only

I:
- ○ think the appearance of my mouth is excellent
- ○ think the appearance of my mouth is adequate
- ○ wish I could change the appearance of my mouth

I:
- ○ want to save my teeth at all costs
- ○ think the appearance of my mouth is excellent
- ○ wish I could change the appearance of my mouth

I:
- ○ have set goals to achieve optimum oral health with a previous dentist
- ○ want to set goals to achieve optimum oral health
- ○ am not very interested in setting personal goals to achieve optimum oral health

I:
- ○ have followed the recommendations for optimum dental health given by my dentist
- ○ have not done what dentists have recommended I do with my mouth
- ○ usually only go to the dentist if I have an emergency

On a scale of 1 to 10, with 10 being the highest, where do you think your teeth are? ____

Where would you like them to be? ____

On a scale of 1 to 10, with 10 being the highest, please rate your fear of the dentist? ____

Is there anything we can do to help you feel more comfortable? ____

Are there any questions about dentistry you have never had adequately answered? ____

Name:

DeMers Dental

PATIENT HISTORY AND INFORMATION

Although dental personnel primarily treat the area in and around the mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

PRIMARY CARE PHYSICIAN

Primary Care Physician and Clinic Name

Address of Primary Care Physician | City | State | Zip | Phone

Question	Yes	No	If yes, please explain:
Are you under a physician's care now?	○ Yes	○ No	
Have you ever been hospitalized or had a major operation?	○ Yes	○ No	
Have you ever had a serious head or neck injury?	○ Yes	○ No	
Are you taking any medications, supplements, pills or drugs?	○ Yes	○ No	
Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?	○ Yes	○ No	
Do you take a premedication (antibiotic) before dental appointments?	○ Yes	○ No	
Are you on a special diet?	○ Yes	○ No	
Do you use tobacco?	○ Yes	○ No	

Women: Are you

- ☐ Pregnant?
- ☐ Nursing?
- ☐ Taking oral contraceptives?

Are you allergic to any of the following:

- ☐ Aspirin
- ☐ Penicillin
- ☐ Codeine
- ☐ Acrylic
- ☐ Metal
- ☐ Latex
- ☐ Local Anesthetics
- ☐ Sulfa
- ☐ Other

If yes, please explain:

Do you have, or have you had, any of the following?

☐ AIDS/HIV Positive	☐ Cortisone Medicine	☐ Hemophilia	☐ Radiation Treatments
☐ Alzheimer's Disease	☐ Diabetes	☐ Hepatitis A	☐ Recent Weight Loss
☐ Anaphylaxis	☐ Drug Addiction	☐ Hepatitis B or C	☐ Renal Dialysis
☐ Anemia	☐ Easily Winded	☐ Herpes	☐ Rheumatic Fever
☐ Angina	☐ Emphysema	☐ High Blood Pressure	☐ Rheumatism
☐ Apnea	☐ Epilepsy or Seizures	☐ High Cholestorol	☐ Scarlet Fever
☐ Arthritis/Gout	☐ Excessive Bleeding	☐ Hives or Rash	☐ Shingles
☐ Artificial Heart Valve	☐ Excessive Thirst	☐ Hypoglycemia	☐ Sickle Cell Disease
☐ Artificial Joint	☐ Fainting Spells/Dizziness	☐ Irregular Heartbeat	☐ Sinus Trouble
☐ Asthma	☐ Frequent Cough	☐ Kidney Problems	☐ Spina Bifada
☐ Blood Disease	☐ Frequent Headaches	☐ Leukemia	☐ Stomach/Intestinal Disease
☐ Blood Transfusion	☐ Genital Herpes	☐ Liver Disease	☐ Stroke
☐ Breathing Problem	☐ Glaucoma	☐ Low Blood Pressure	☐ Swelling of Limbs
☐ Bruise Easily	☐ Acid Reflux	☐ Lung Disease	☐ Thyroid Disease
☐ Cancer	☐ Heart Attack/Failure	☐ Sleep Problems / Apnea	☐ Tonsillitis
☐ Chemotherapy	☐ Heart Murmur	☐ Osteoporosis	☐ Tuberculosis
☐ Chest Pains	☐ Heart Pace Maker	☐ Pain in Jaw Joints	☐ Tumors or Growths
☐ Cold Sores/Fever Blisters	☐ Heart Trouble/Disease	☐ Parathyroid Disease	☐ Ulcers
☐ Congenital Heart Disorder		☐ Psychiatric Care	☐ Venereal Disease
☐ Convulsions			
☐ Yellow Jaundice			

Have you ever had any serious illness or injury not listed above? ○ Yes ○ No If yes, please explain:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my resonsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ______________________ DATE ______________

Name:

DeMers Dental
INSURANCE INFORMATION

Primary Dental Insurance Information

Employer ______ Employer's Address ______ Work Phone ______

Name and Address of Primary Insurance Company ______

☐ M ☐ F

Insured's First Name ______ MI ______ Insured's Last Name ______

Insured's Identification Number ______ Group Number ______ Insured's Date of Birth ______

Patient Relationship to Insured

☐ Self ☐ Spouse

☐ Child ☐ Other

Patient Status

☐ Single ☐ Married ☐ Other

☐ Full Time Student ☐ Part Time Student ☐ Employed

Secondary Dental Insurance Information

Employer ______ Employer's Address ______ Work Phone ______

Name and Address of Secondary Insurance Company ______

☐ M ☐ F

Insured's First Name ______ MI ______ Insured's Last Name ______

Insured's Identification Number ______ Group Number ______ Insured's Date of Birth ______

Patient Relationship to Insured

☐ Self ☐ Spouse

☐ Child ☐ Other

Medical Insurance Information

Employer ______ Employer's Address ______ Work Phone ______

Name and Address of Primary Insurance Company ______

☐ M ☐ F

Insured's First Name ______ MI ______ Insured's Last Name ______

Insured's Identification Number ______ Group Number ______ Insured's Date of Birth ______