Portash Dental

Patient Information

Name:_____ Date:_____

SS#: _____ Birth Date:_____ Home Phone:_____

Address: _____ City:_____ State:_____ Zip:_____

Email:_____ Cell Phone:_____

Check Appropriate Box: ☐Minor ☐Single ☐Married ☐Partnered ☐Divorced

If Student, Name of School/College: _____ City: _____ State: _____ ☐Full ☐Part Time

Patient or Parent/Guardian's Employer: _____ Work Phone: _____

Spouse or Parent/Guardian's Name: _____ Employer: _____ Work Phone: _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of an Emergency: _____ Phone: _____

Responsible Party

Name of Person Responsible for Account: _____ Relation to Patient: _____

Address: _____ City: _____ State: _____ Zip:_____

Drivers License #: _____ Birth Date: _____

Email:_____ Cell Phone:_____ Home Phone: _____

SS# _____ Employer: _____ Work Phone: _____

Insurance Information

Name of Insured: _____ Relationship to Patient: _____

Birth Date: _____ SS#:_____ Date Employed: _____

Name of Employer: _____ Union or Local #_____ Work Phone: _____

Employer Address:_____ City: _____ State:_____ Zip:_____

Insurance Company: _____ Group #:_____ Policy/ID#:_____

Insurance Company Address: _____ City: _____ State: _____ Zip: _____

Do You Have Secondary Insurance? ☐ Yes ☐NO If Yes, Please Complete the Following:

Name of Insured: _____ Relationship to Patient: _____

Birth Date: _____ SS#:_____ Date Employed: _____

Name of Employer: _____ Union or Local #_____ Work Phone: _____

Employer Address:_____ City: _____ State:_____ Zip:_____

Insurance Company: _____ Group #:_____ Policy/ID#:_____

Insurance Company Address: _____ City: _____ State: _____ Zip: _____

Patient Medical History

Physician: _____Office Phone_____ Date of last Physical _____

1. Are you under medical treatment now? ☐ Yes ☐ No
2. Have you ever been hospitalized for any Surgical in/out patient surgery or serious illness with the last 5 years? ☐ Yes ☐ No
3. Are you taking any medication(s) including non prescription medicine? ☐ Yes ☐ No
4. Have you ever taken Fen-Phen/Redux ☐ Yes ☐ No
5. Have you ever taken Fosamax, Boniva, Actonel, or any cancer medications Containing bisphosphonates? ☐ Yes ☐ No
6. Have you ever taken Viagra, Revatio, Cialis or Levitra in the last 24 hours? ☐ Yes ☐ No
7. Do you use Tobacco? ☐ Yes ☐ No
8. Do you use controlled substances? ☐ Yes ☐ No

Please list current medications _____

_____

_____

_____

Are you wearing contact lenses? ☐ Yes ☐ No

Are you allergic to or have you had any reactions to the following?

Local Anesthetics (Novocain)	☐ Yes	☐ No
Penicillin or other Antibiotics	☐ Yes	☐ No
Sulfa Drugs	☐ Yes	☐ No
Barbiturates	☐ Yes	☐ No
Sedatives	☐ Yes	☐ No
Iodine	☐ Yes	☐ No
Aspirin	☐ Yes	☐ No
Any Metals (nickel, mercury, etc.)	☐ Yes	☐ No
Latex Rubber	☐ Yes	☐ No
Other _____	☐ Yes	☐ No

Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? ☐ Yes ☐ No

Women Only:

Are you pregnant or think you may be pregnant? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

Are you taking oral contraceptives? ☐ Yes ☐ No

Do you have any of the following?

High Blood Pressure	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Chest Pains	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No	Cardiac Pacemaker	☐ Yes	☐ No	Easily Winded	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Swollen Ankles	☐ Yes	☐ No	Angina	☐ Yes	☐ No	Hay Fever/Allergies	☐ Yes	☐ No
Fainting/Seizures	☐ Yes	☐ No	Frequently Tired	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Anemia	☐ Yes	☐ No	Radiation Therapy	☐ Yes	☐ No
Low Blood Pressure	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No
Epilepsy/Convulsions	☐ Yes	☐ No	Cancer	☐ Yes	☐ No	Recent Weight Loss	☐ Yes	☐ No
Leukemia	☐ Yes	☐ No	Arthritis	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Joint Replacement/Implant	☐ Yes	☐ No	Heart Trouble	☐ Yes	☐ No
Kidney Diseases	☐ Yes	☐ No	Hepatitis/Jaundice	☐ Yes	☐ No	Respiratory Problems	☐ Yes	☐ No
AIDS or HIV Infection	☐ Yes	☐ No	STD	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No
Thyroid Problem	☐ Yes	☐ No	Stomach Trouble/Ulcers	☐ Yes	☐ No	Other _____	☐ Yes	☐ No

Patient Dental History

Name of previous dentist: _____ Date of last Exam _____

Location: _____ Date of last Cleaning _____

Do your gums bleed while brushing or flossing? ☐ Yes ☐ No

Are your teeth sensitive to hot or cold liquids/foods? ☐ Yes ☐ No

Are your teeth sensitive to sweet or sour liquid/foods? ☐ Yes ☐ No

Do you feel pain to any of your teeth? ☐ Yes ☐ No

Do you have sores or lumps in or near your mouth? ☐ Yes ☐ No

Have you had any head, neck, or jaw injuries? ☐ Yes ☐ No

Have you ever experienced any of the following to problems in your jaw?

- Clicking ☐ Yes ☐ No
- Pain- joint, ear, side of face ☐ Yes ☐ No
- Difficulty opening/closing ☐ Yes ☐ No
- Difficulty chewing ☐ Yes ☐ No

Do you have frequent headaches? ☐ Yes ☐ No

Do you clench or grind your teeth? ☐ Yes ☐ No

Do you bite your lips or cheeks frequently? ☐ Yes ☐ No

Have you ever had any difficult extractions? ☐ Yes ☐ No

Have you ever had prolonged bleeding following extractions? ☐ Yes ☐ No

Have you had braces? ☐ Yes ☐ No

Do you wear partials/dentures? ☐ Yes ☐ No

Have you ever received oral hygiene instructions regarding the care of your teeth and gums? ☐ Yes ☐ No

Do you like your smile? ☐ Yes ☐ No

Authorization and Release- I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

Signature of patient: _____ Date: _____