

WELCOME TO OUR OFFICE

PATIENT INFORMATION

NAME: _____ DOB: _____ SS# _____
HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____
OCCUPATION: _____ EMPLOYER: _____
EMPLOYER'S ADDRESS: _____
SPOUSE'S EMPLOYER: _____ WORK PHONE: _____

DENTAL INSURANCE INFORMATION

NAME OF INSURANCE CARRIER: _____
ADDRESS OF INSURANCE CARRIER: _____
GROUP/POLICY # _____ PHONE NUMBER: _____
NAME OF INSURED: _____ SS# _____
ADDRESS: _____ ZIP CODE: _____
RELATIONSHIP TO PATIENT: _____ DOB: _____
OCCUPATION: _____ EMPLOYER: _____
EMPLOYER'S ADDRESS: _____ WORK PHONE: _____

BILLING INFORMATION

RESPONSIBLE PARTY: _____ SS# _____ DRIVER'S LICENSE: _____
ADDRESS: _____ ZIP CODE: _____

REFERRAL INFORMATION

REFERRED BY: _____

I have completed this form fully and completely, and I certify that I am the patient or duly authorized agent of the patient authorized to furnish the information requested. I hereby authorize release of information regarding my dental treatment to my insurance company. I understand that even though I may have dental insurance, that I am responsible for payment for all services. If my account becomes past due, I understand all necessary steps will be taken to collect this debt. In the event that suit or outside collections are necessary to enforce payment of the account, the patient agrees to pay for all collection fees and /or attorney's fees and court costs as may be deemed reasonable.

PREFERRED METHOD OF PAYMENT: _____ CHECK _____ CASH _____ CREDIT CARD

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY: _____

DATE: _____

Medical History Form

Name _____ Home Phone (____) _____
Last First Middle

Address _____ Business Phone (____) _____
Number, Street

City _____ State _____ Zip Code _____

Occupation _____ Social Security No. _____

Date of Birth / / Sex M F Height _____ Weight _____ Single _____ Married _____
mo. day yr.

Name of Spouse _____ Closest Relative _____ Phone (____) _____

If you are completing this form for another person, what is your relationship to that person? _____

Referred by _____

For the following questions, *circle yes or no*, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

- | | | |
|--|-----|----|
| 1. Are you in good health? | Yes | No |
| 2. Has there been any change in your general health within the past year? | Yes | No |
| 3. My last physical examination was on _____ | | |
| 4. Are you now under the care of a physician? | Yes | No |
| If so, what is the condition being treated? _____ | | |
| 5. The name and address of my physician(s) is _____ | | |
| _____ | | |
| _____ | | |
| 6. Have you had any serious illness, operation, or been hospitalized in the past 5 years? | Yes | No |
| If so, what was the illness or problem? _____ | | |
| 7. Are you taking any medicine(s) including non-prescription medicine? | Yes | No |
| If so, what medicine(s) are you taking? _____ | | |
| 8. Do you have or have you had any of the following diseases or problems? | | |
| a. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease | Yes | No |
| b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) | | |
| 1. Do you have chest pain upon exertion? | Yes | No |
| 2. Are you ever short of breath after mild exercise or when lying down? | Yes | No |
| 3. Do your ankles swell? | Yes | No |
| 4. Do you have inborn heart defects? | Yes | No |
| 5. Do you have a cardiac pacemaker? | Yes | No |
| c. Allergy | Yes | No |
| d. Sinus trouble | Yes | No |
| e. Asthma or hay fever | Yes | No |
| f. Fainting spells or seizures | Yes | No |
| g. Persistent diarrhea or recent weight loss | Yes | No |
| h. Diabetes | Yes | No |
| i. Hepatitis, jaundice or liver disease | Yes | No |
| j. AIDS or HIV infection | Yes | No |
| k. Thyroid problems | Yes | No |
| l. Respiratory problems, emphysema, bronchitis, etc | Yes | No |
| m. Arthritis or painful swollen joints | Yes | No |
| n. Stomach ulcer or hyperacidity | Yes | No |
| o. Kidney trouble | Yes | No |
| p. Tuberculosis | Yes | No |
| q. Persistent cough or cough that produces blood | Yes | No |
| r. Persistent swollen glands in neck | Yes | No |
| s. Low blood pressure | Yes | No |
| t. Sexually transmitted disease | Yes | No |
| u. Epilepsy or other neurological disease | Yes | No |
| v. Problems with mental health | Yes | No |
| w. Cancer | Yes | No |
| x. Problems of the immune system | Yes | No |

- | | | |
|---|-----|----|
| 9. Have you had abnormal bleeding? | Yes | No |
| a. Have you ever required a blood transfusion? | Yes | No |
| 10. Do you have any blood disorder such as anemia? | Yes | No |
| 11. Have you ever had any treatment for a tumor or growth? | Yes | No |
| 12. Are you allergic or have you had a reaction to: | | |
| a. Local anesthetics | Yes | No |
| b. Penicillin or other antibiotics | Yes | No |
| c. Sulfa drugs | Yes | No |
| d. Barbiturates, sedatives, or sleeping pills | Yes | No |
| e. Aspirin | Yes | No |
| f. Iodine | Yes | No |
| g. Codeine or other narcotics | Yes | No |
| h. Other _____ | | |
| 13. Have you had any serious trouble associated with any previous dental treatment? | Yes | No |
| If so, explain _____ | | |
| 14. Do you have any disease, condition, or problem not listed above that you think I should know about? | Yes | No |
| If so, explain _____ | | |
| 15. Are you wearing contact lenses? | Yes | No |
| 16. Are you wearing removable dental appliances? | Yes | No |
| 17. Do you smoke? | Yes | No |
| Women | | |
| 18. Are you pregnant? | Yes | No |
| 19. Do you have any problems associated with your menstrual period? | Yes | No |
| 20. Are you nursing? | Yes | No |
| 21. Are you taking birth control pills? | Yes | No |

Chief Dental Complaint _____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient

For completion by the dentist.

Comments on patient interview concerning medical history: _____

Significant findings from questionnaire or oral interview: _____

Dental management considerations: _____

(Date) _____ Signature of Dentist _____

Medical history update:

Date	Comments	Signature
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____



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DR. MICHAEL G. WILEY, DDS, MS

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