Mountain Dental PC

Patient Information

Patient Name: _____ Date _____
(Last, First, MI, Preffered Name You Go By)
Gender (M/F): _____ Marital Status (M/S): _____ Birth Date: _____ Social Security #: _____
Driver's License #: _____ E-Mail Address: _____
Address: _____
(Street, Appartment #)
_____
(City, State, Zip Code)
Phone Numbers: Home _____ Work _____ Ext _____ Best Time to Call: _____
FAX _____ Pager _____ Other _____
Emergency Contact _____

Referal Information

Name of person, office or other source referring you to our practice:

_____

Spouse or Responsible Party Information

Name: _____ Date _____
(Last, First, MI, Preffered Name You Go By)
Gender (M/F): _____ Marital Status (M/S): _____ Birth Date: _____ Social Security #: _____
Driver's License #: _____ E-Mail Address: _____
Address: _____
(Street, Appartment #)
_____
(City, State, Zip Code)
Phone Numbers: Home _____ Work _____ Ext _____ Best Time to Call: _____
FAX _____ Pager _____ Other _____
Emergency Contact _____

Employment Information

The Following is for ☐ the patient ☐ the person responsible for payment
Employer Name: _____
Address: _____
(Street, City, State, Zip Code, Phone)

Insurance Information

Primary

Name of Insured: _____
Insured's Birth Date: _____ ID#: _____ Goup#: _____
Insured's Address: _____
(Street, City, State, Zip Code)
Insured's Employer Name: _____
Address: _____
(Street, City, State, Zip Code)
Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other
Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____
Insured's Birth Date: _____ ID#: _____ Goup#: _____
Insured's Address: _____
(Street, City, State, Zip Code)
Insured's Employer Name: _____
Address: _____
(Street, City, State, Zip Code)
Patient's relationship to insured: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**
Insurance Plan Name and Address: _____

_____

TODD SUTTON DDS

Mountain Dental PC

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UPDATE

DATE	B P	CHANGES	INITIAL

Medical History of Patient (Please circle any of the following which you have had or have at present):

Heart disease / condition	Rheumatic fever	Hay fever	Sicle Cell disease
Angina Pectoris	Hemophilia	Emphysema	Fainting / Dizzy spells
Frequent chest pains	Bruise easily	Tuberculosis	Epilepsy or siezures
High Blood Pressure	Diabetes	Chemotherapy	Prolonged bleeding
Artificial heart valve	Blood transfusion	Kidney trouble	Radiation therapy
Drug addiction	Heart Murmur	Liver disease	Thyroid disease
Joint replacement	Arthritis	Cold Sores	Jaundice
Hepatitis	Cancer	Glaucoma	Stroke
HIV positive	Osteoporosis	Congenital Heart disease	Asthma
Dry mouth			

Do you have any other diseases or conditions not listed above? Yes No If yes, please explain: _____

_____

Do you use or have you ever used tobacco pruducts? Please specify: _____

_____

Do you consume more than three (3) suger drinks per day? (e.g.- Soda, Kool-Aid, Sports drinks, Juices): _____

_____

Have you ever been told you were not eligible to be a blood donor? Yes No If yes, please explain: _____

_____

Are you sensitive (allergic) to any medicine, drugs or metals? Yes No If yes, please list what you are allergic to:

_____

Are you pregnant? Yes No N/A Do you take birth control? Yes No

Are you taking any medication (prescription or over-the-counter)? If so, please list: _____

_____

Do your gums bleed? Yes No Does food collect between teeth Yes No Loose teeth? Yes No

Do you like the looks and the function of your teeth? Yes No

Year of last physical exam with a physician: _____

Year of last dental exam and X-rays: _____

Signature _____ **Date** _____