

**ELKTON BEAR DENTAL
PATIENT INFORMATION**

Name: _____ I prefer to be called: _____

Home Phone: _____ Cell Phone: _____ E-Mail: _____

Home address: _____
STREET CITY STATE ZIP CODE

Birth Date: _____ Patient's Age: _____ Sex: M / F Social Security #: _____

Place of Employment: _____ Telephone: _____

Business Address: _____
STREET CITY STATE ZIP CODE

Marital Status: _____ Single _____ Married _____ Separated _____ Widowed _____ Divorced

Spouse's Name: _____ Spouse's DOB: _____ Spouse's SSN#: _____

Spouse Employed By: _____ Telephone: _____

How did you hear about our office (please circle)? Friend or relative Insurance Company Our Website Drove by the office Search Engine
(google,etc.) Advertisement Other: _____

If referred, who may we thank? _____

INSURANCE INFORMATION

(please provide a copy of your insurance card)

Policy Holder: _____ Insurance Company: _____

Policy Number: _____ Employer: _____

INSURANCE AUTHORIZATION AND CONSENT FOR TREATMENT

All of the above information is correct to the best of my knowledge. I authorize use of this form on all of my insurance submissions and I authorize the release of information to my insurance company(s). I understand that I am responsible for my bill. I authorize Elkton Bear Dental Arts and the office of Dr. Jessica Baker to act as my agent in helping me to obtain payment from my insurance company. I authorize payment to Elkton Bear Dental Arts / Dr. Jessica Baker. I permit a copy of this authorization to be used in place of the original. I give this dental office, its employees, and/or other agents express prior consent to contact me at any/all phone numbers (by phone call or text message) and e-mail addresses, for the purpose of appointment reminders, treatment, insurance or payment.

I hereby authorize Dr. Jessica Baker or her designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by the doctor in order to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize Dr. Jessica Baker to perform all recommended treatment which has been mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and other medications to make my visit more comfortable. I understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications. I have read, understood and agreed to the above information.

PATIENT SIGNATURE DATE

MEDICAL HISTORY

Name of Family Doctor: _____ Telephone: _____

1. Are you under medical treatment now? If so, for what condition(s)? _____

2

2. Are you currently taking any medications? If so, please list _____

3.

Are you allergic to any medications? If so, please list: _____

4. Do you use tobacco in any form? If yes, how much? _____

5. (Women) are you pregnant? If yes, what is your due date? _____

6. Have you ever had trouble with bleeding after surgery? ____ Yes ____ No

7. Do you have or have you ever had any of the following conditions? (please check all that apply) ____ High Blood Pressure ____

Kidney or Liver Disease ____ Anemia ____ Psychiatric Treatment ____ Prosthetic Heart Valve ____ Infectious Disease (TB, HIV, AIDS) ____

Diabetes ____ Cancer ____ Bacterial Endocarditis ____ Any Blood Diseases ____ Stroke ____ Radiation Treatment ____ Cardiac Valvulitis ____

Asthma ____ Seizures ____ Chemotherapy ____ Latex Allergy ____ Artificial Joints Or Limb ____ Arthritis ____ Acid Reflux ____ Congenital

Heart Disease (Other Than Mitral Valve Prolapse) Other: _____

8. Do you require antibiotic pre-medication for your dental work? If yes, what condition? _____

9. Is there any other information that we should know about your health? Please describe: _____

1

10. If necessary, may we contact your medical doctor regarding your care? ____ Yes ____ No

11. Do you wish to talk to the dentist privately about any problems or concerns? ____ Yes ____ No

12. What is your pharmacy of choice if we need to call in any prescriptions? _____

DENTAL HISTORY

1. What is the reason for your for your visit today? _____
2. What is the best description of your past dental treatment? Please check one of the following: ___ At Least 2 Visits A Year
___ At Least Once A Year ___ Only When I Have A Problem ___ About Once Every 2 – 3 Years
3. If you have ever had a bad dental experience, please describe: _____
4. If you are nervous about dental treatment, please explain: _____
5. Would you be interested in taking a pill to relax you for dental treatment (oral sedation)? ___ Yes ___ No
6. Have you ever had an adverse reaction to dental anesthetic? If yes, please describe: _____
7. Do you have any upcoming event or circumstances (such as weddings, major surgeries, losing insurance, etc.) that we should or need to know about? If so, what and when? _____

GUM DISEASE

8. Do you experience frequent bad breath? ___ Yes ___ No
9. Do your gums bleed when you brush or floss your teeth? ___ Yes ___ No
10. Have you ever been diagnosed with gum disease (periodontal disease)? ___ Yes ___ No

TMJ/SLEEP APNEA

11. Do you have any problems with the following? Check all that apply: ___ Sleepiness ___ Tension Headaches
___ Sore Teeth ___ Grind teeth ___ Problems with your jaw joint (pain, locking, clicking, limited opening, etc.)
12. Have you ever worn a mouthguard or bite appliance? ___ Yes ___ No
13. Have you ever been diagnosed with Sleep Apnea or participated in a sleep study? ___ Yes ___ No
14. Do you snore or have been told you stop breathing in your sleep (gasp for air)? ___ Yes ___ No

SMILE/FACIAL ESTHETICS

15. Is there anything you would like to change about your teeth or smile? If so, what? _____
16. Do you have any broken or missing teeth that you would like to have fixed or replaced? ___ Yes ___ No
17. Are you interested in any of the following? Check all that apply:
___ Straighter Teeth (with Clear Braces) ___ Closing Spaces ___ Whiter Teeth ___ White Fillings
18. Have you ever had any type of facial injectables like Botox or Dermal Fillers? ___ Yes ___ No
19. Are you interested in reducing frown lines, forehead lines or smile lines around the eyes? ___ Yes ___ No
20. Are you interested in talking with the doctor about your options for botox and/or fillers? ___ Yes ___ No

All of the above information is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in my medical status. I understand that this information is necessary to provide me with dental care in a safe and efficient manner.

_____ PATIENT SIGNATURE/DATE

_____ STAFF/WITNESS SIGNATURE/DATE