PATIENT INFORMATION

Patient Name: _____
Last First MI (Preferred)

Date of Birth: _____ SS #: _____ Gender: ☐ M ☐ F

Home #: _____ Cell #: _____ Work #: _____

Email Address: _____

Preferred Method of Contact: ☐ HmPhone ☐ WkPhone ☐ CellPhone ☐ Email ☐ TextMesssage

Preferred Contact for Confirmations: ☐ HmPhone ☐ WkPhone ☐ CellPhone ☐ Email ☐ TextMesssage

Preferred Contact for Recall/Recare: ☐ HmPhone ☐ WkPhone ☐ CellPhone ☐ Email ☐ TextMesssage

Student status if dependent over 19 (for ins): ☐ Nonstudent ☐ Fulltime ☐ Parttime

How did you hear about our office? (If someone referred you here, please enter their name so we can thank them.)

_____

Check box if your address is the same for your entire family: ☐

Address: _____

Address 2: _____

City: _____ State: _____ Zip: _____

EMERGENCY CONTACT: _____
Full Name Relationship to Patient Phone #

Insurance Policy 1

Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

Subscriber Name: _____ SS # / Subscriber ID #: _____

Subscriber Date of Birth: _____

Insurance Carrier: _____ Ins. Phone: _____

Employer: _____ Group Name: _____ Group #: _____

Insurance Policy 2

Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

Subscriber Name: _____ SS # / Subscriber ID #: _____

Subscriber Date of Birth: _____

Insurance Carrier: _____ Ins. Phone: _____

Employer: _____ Group Name: _____ Group #: _____

_____ _____

Patient/Guardian Signature Date

Release of Health Information

Patient Name: (Last) (First)

Date of Birth:

I give my permission for my previous dental records to be released to the office of

Dr. Phillip Platt, DDS
Prairie Creek Dental
14533 E Highway 12
Rogers, AR 72756
(P) 479 - 925 - 3632
(F) 479 - 925 - 3660
(E) prairiecreekdental@gmail.com

Health information identifies you (the patient) by name, and included other demographic information about you. Health informatin may include, but is not imited to: medical records, x-rays, study models, etc.

Health information that may be used/disclosed is limited to the following:

- ☐ Radiographs (digital and panoramic x-rays)
- ☐ Records
- ☐ Diagnostic Study Casts

This authorization will automatically expire 60 days after the date of the signature below unless an earlier date is specified or at the conclusion of the specific event. I understand that I have a right to evoke this authorization at any time in writing.

Patient or Authorized Guardian Signature

Date

MEDICAL HISTORY

Last Name: _____ First Name: _____ Date of Birth: _____

Name of Physician/and their specialty: _____

Date of last physical exam: _____ Purpose for last exam: _____

What is your estimate of your general health? (please check) ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE EVER HAD THE FOLLOWING:

Y / N

- ☐☐ Hospitalization for illness or injury
- ☐☐ Allergy - Acetaminophen
- ☐☐ Allergy - Codeine
- ☐☐ Allergy - Penicillin
- ☐☐ Allergy - Erythromycin
- ☐☐ Allergy - Tetracycline
- ☐☐ Allergy - Sulfa
- ☐☐ Allergy - Local Anesthetic
- ☐☐ Allergy - Fluoride
- ☐☐ Allergy - Metals (nickel, gold, silver, _____)
- ☐☐ Allergy - Latex
- ☐☐ Allergy - Other _____
- ☐☐ Heart problems, or cardiac stent
- ☐☐ History of infective endocarditis
- ☐☐ Artificial heart valve, repaired heart defect (PFO)
- ☐☐ Pacemaker or implantable defibrillator
- ☐☐ Orthopedic implant (joint replacement)
- ☐☐ Rheumatic or scarlet fever
- ☐☐ High or low blood pressure
- ☐☐ A stroke (taking blood thinners)
- ☐☐ Anemia or other blood disorder
- ☐☐ Prolonged bleeding due to a slight cut (INR>3.5)
- ☐☐ Emphysema, shortness of breath, sarcoidosis
- ☐☐ Tuberculosis, measles, chicken pox
- ☐☐ Asthma
- ☐☐ Breathing or sleep problems (i.e. sleep apnea, snoring, sinus)
- ☐☐ Kidney Disease
- ☐☐ Liver Disease
- ☐☐ Jaundice
- ☐☐ Thyroid, parathyroid disease, or calcium deficiency
- ☐☐ Hormone deficiency
- ☐☐ High cholesterol or taking statin drugs
- ☐☐ Diabetes (HbA1C = _____)
- ☐☐ Stomach or duodenal ulcer
- ☐☐ Digestive disorders (i.e. celiac disease, gastric reflux)
- ☐☐ Osteoporosis / osteopenia (i.e. taking bisphosphonates)

Y / N

- ☐☐ Allergy - Aspirin
- ☐☐ Allergy - Ibuprofen

Y / N

- ☐☐ Arthritis
- ☐☐ Autoimmune disease (i.e. rheumatoid arthritis, lupus, scleroderma)
- ☐☐ Glaucoma
- ☐☐ Contact Lenses
- ☐☐ Head or neck injuries
- ☐☐ Epilepsy, convulsions (seizures)
- ☐☐ Neurologic disorders (ADD/ADHD, prion disease)
- ☐☐ Viral infections and cold sores
- ☐☐ Any lumps or swelling in the mouth
- ☐☐ Hives, skin rash, hay fever
- ☐☐ STI / STD / HPV
- ☐☐ Hepatitis (Type_____)
- ☐☐ HIV / AIDS
- ☐☐ Tumor, abnormal growth
- ☐☐ Radiation Therapy
- ☐☐ Chemotherapy, immunosuppressive medication
- ☐☐ Emotional difficulties
- ☐☐ Psychiatric Treatment
- ☐☐ Antidepressant medication
- ☐☐ Alcohol and/or recreational drug use

ARE YOU:

- ☐☐ Presently being treated for any other illness
- ☐☐ Aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea)
- ☐☐ Taking medication for weight management
- ☐☐ Taking dietary supplements
- ☐☐ Often exhausted or fatigued
- ☐☐ Experiencing frequent headaches
- ☐☐ A smoker, smoked previously or use smokeless tobacco
- ☐☐ Considered a touchy / sensitive person
- ☐☐ Often unhappy or depressed
- ☐☐ Taking birth control
- ☐☐ Currently Pregnant
- ☐☐ Prostate disorders

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

_____

List all medications, supplements and/or vitamins taken within the last 2 years:

_____ _____

_____ _____

_____ _____

_____ _____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING

_____ _____

Patient/Guardian Signature Date

DENTAL HISTORY

Last Name: _____ First Name: _____ Date of Birth: _____

How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist: _____

Date of most recent dental exam: _____ Date of most recent x-rays: _____

Date of most recent treatment (other than a cleaning): _____

I routinely see my dentist every: ☐ 3 Months ☐ 4 Months ☐ 6 Months ☐ 12 Months ☐ Not Routinely

What is your immediate concern? _____

What are your personal LONG TERM dental goals for your dental health and smile? Please explain.

_____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

Personal History

	YES	NO
Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) _____	☐	☐
How do you prefer to receive information about your dental health? Please Check one. ☐ Short, sweet and to the point ☐ Very detailed ☐ Somewhere in between the two		
Have you had an unfavorable dental experience?	☐	☐
Have you ever had complications from past dental treatment?	☐	☐
Have you ever had trouble getting numb or had any reactions to local anesthetic?	☐	☐
Did you ever have braces, orthodontic treatment or had your bite adjusted?	☐	☐
Have you had any teeth removed or missing teeth that never developed?	☐	☐

Smile Characteristics

	YES	NO
Is there anything about the appearance of your teeth that you would like to change?	☐	☐
Have you ever whitened (bleached) your teeth?	☐	☐
Have you felt uncomfortable or self conscious about the appearance of your teeth?	☐	☐
Have you been disappointed with the appearance of previous dental work?	☐	☐

Bite and Jaw Joint

	YES	NO
Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	☐	☐
Do you feel like your lower jaw is being pushed back when you bite your teeth together?	☐	☐
Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	☐	☐
Have your teeth changed in the last 5 years, become shorter, thinner or worn?	☐	☐
Are your teeth becoming more crooked, crowded, or overlapped?	☐	☐
Are your teeth developing spaces or becoming more loose?	☐	☐
Do you have more than one bite, sqeeze, or shift your jaw to make your teeth fit together?	☐	☐
Do you place your tongue between your teeth or close your teeth against your tongue?	☐	☐
Do you chew ice, bite your nails, use your teeth to hold objects or have any other oral habits?	☐	☐
Do you clench your teeth in the daytime or make them sore?	☐	☐
Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth?	☐	☐
Do you wear or have you ever worn a bite appliance?	☐	☐

Tooth Structure

	YES	NO
Have you had any cavities within the past 3 years?	☐	☐
Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	☐	☐
Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	☐	☐
Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth?	☐	☐
Do you have grooves or notches on your teeth near the gum line?	☐	☐
Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	☐	☐
Do you frequently get food caught between any teeth?	☐	☐

Gum and Bone

	YES	NO
Do your gums bleed or are they painful when brushing or flossing?	☐	☐
Have you ever been treated for gum disease or been told you have lost bone around your teeth?	☐	☐
Have you ever noticed an unpleasant taste or odor in your mouth?	☐	☐
Is there anyone with a history of periodontal disease in your family?	☐	☐
Have you ever experienced gum recession?	☐	☐
Have you ever had any teeth become loose (without injury), or do you have difficulty eating an apple?	☐	☐
Have you experienced a burning or painful sensation in your mouth not related to your teeth?	☐	☐

ANY OTHER INFORMATION RELEVANT TO YOUR DENTAL CARE NOT LISTED ABOVE?

I understand that my insurance is an agreement between me and my insurance company.
I also understand that I am responsible for my balance regardless of my insurance.

I assign dental benefit payments to be paid direclty to Prairie Creek Dental from my insurance company.

Patient/Guardian Signature

Date