ANDREW MARTINSSEN, DDS

Patient Dental Health

What concern brought you to our office today? (e.g.: pain, checkup, etc.) _____

Previous Dentist _____ Last visit _____ Date of last cleaning _____

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ○ Yes ○ No

What problems have you had with past dental treatment? _____

Are you nervous about seeing a dentist? ○ Yes ○ No If yes, please tell us why: _____

How often do you brush? _____ Do you floss? ○ Yes ○ No If yes, how often? _____

(Please circle each)

Y N I clench or grind my teeth during the day or while sleeping
Y N My gums bleed while brushing or flossing
Y N I like my smile
Y N I prefer tooth-colored fillings
Y N I have had a facial or jaw injury
Y N My gums feel tender or swollen
Y N I have problems eating
Y N I had orthodontics
Y N I avoid brushing part of my mouth due to pain
Y N I want my teeth whiter

What are your dental priorities? _____

(e.g.: appearance, dental health, financial considerations, etc.)

Patient Medical Health History

I consider my health to be *(please check one)* ○ Excellent ○ Good ○ Fair ○ Poor

Do you or have you had any of the following? *(please circle **all** that apply)*

Doctor Notes:

Y N Heart Surgery/Pacemaker
Y N Heart Murmur/Mitral Valve Prolapse
Y N Heart Attack/Stroke
Y N Congenital Heart Lesions/Defect
Y N Rheumatic/Scarlet Fever
Y N High/Low Blood Pressure
Y N Anemia
Y N Abnormal/Prolonged Bleeding
Y N Tuberculosis (TB) or Lung Disease
Y N Immunosuppressive Disorder
Y N Hay Fever
Y N Sinus Problems
Y N Epilepsy/Seizures/Fainting
Y N Thyroid Problems
Y N Liver Disease
Y N Jaundice
Y N Hepatitis Type _____
Y N Diabetes
Y N Kidney Problems
Y N Herpes/Fever Blisters
Y N Difficulty Breathing
Y N Cancer/Chemotherapy
Y N Radiation Treatment
Y N Excessive Urination and/or Thirst
Y N Alcohol/Drug Abuse
Y N Venereal Disease
Y N Psychiatric Problems
Y N Blood Transfusion
Y N HIV/AIDS
Y N Glaucoma
Y N Asthma
Y N Hearing Loss
Y N Shingles
Y N Lupus
Y N Ulcers/Colitis
Y N Hemophilia
Y N Emphysema
Y N Artificial Bones/Joints: ○ Hip ○ Knee ○ Other _____
Y N I smoke and/or use tobacco. If yes, how much per day? _____ How many years? _____
Y N I have consumed alcohol within the last 24 hours.
Y N I usually take as antibiotic prior to my dental appointment. How long _____
Y N I have had major surgery/hospitalization _____
Y N Do you have any other medical problems or medical history NOT listed on this form? *(please list if any)* _____

Women ONLY: Are you pregnant? ○ Yes ○ No Week # _____ Are you nursing? ○ Yes ○ No

Are you using a prescribed method of birth control? ○ Yes ○ No If yes, please read and sign the following:

I have informed my doctor about my use of birth control pills. I have been advised that certain antibiotics and dental anesthesia may neutralize the preventive effect of birth control pills, allowing for conception and pregnancy. I agree to consult with my personal physician to initiate additional forms of birth control during the period of my treatment, and to continue those methods until advised by my personal physician that I can return to the use of oral birth control pills.

Patient's Signature _____ **Date** _____

Are you allergic to any of the following?

Y N Aspirin
Y N Penicillin
Y N Latex
Y N Tetracycline
Y N Codeine
Y N Metal/Plastics
Y N Dental Anesthetics
Y N Erythromycin

Please list all medication s you are currently taking:

Medication _____
Medication _____
Medication _____
Medication _____

I understand that information that I have given today is correct to the best of my knowledge. I also understand that it is my responsibility to inform this office of any charges in my medical status.

Signature _____ Date _____

ANDREW MARTINSSEN, DDS

GETTING TO KNOW YOU AS OUR PATIENT

Please Print

Today's Date _____

Patient Name	SS Number	Best Phone Number
Home Address	City, State, Zip	Birthday
Marital Status: ○ Married ○ Single ○ Divorced ○ Widowed Sex: ○ Male ○ Female	Employer Occupation	Alternate Number Alternate Number

Email Address_____ May we contact you by email? ○ Yes ○ No Mark here if you want to receive text messages ○

How did you hear about our office? _____ Who may we thank for referring you?_____

Please follow us on Facebook and visit our website www.amartinssendds.com

Insurance Information

Do you have a Dental Insurance? ○ Yes ○ No

Insurance Company Name_____

Insured's Name_____

Insurance Company Address_____

Insurance Company Phone_____

Group#, Name and Policy_____

Insured's Birthdate____/____/_____Insured's ID_____

Do you have a Secondary Dental Insurance? ○ Yes ○ No

Insurance Company Name_____

Insured's Name_____

Insurance Company Address_____

Insurance Company Phone_____

Group #, Name and Policy_____

Insured's Birthday____/____/_____Insured's ID_____

Terms and Conditions

Payment is due at or before time of service. If I carry insurance, I understand that this office will help me prepare necessary insurance forms to assist me in making collection from my insurance company. Also, I understand that I am responsible for payment of services rendered and responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to this office of the group of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. Also, I hereby authorize any release of information, included the diagnosis and records of treatment, examination rendered, to my insurance company.

Signature _____ Date _____

Our office is HIPPA compliant and is committed to meeting or exceeding the standards of infection control mandates by OSHA, the CDC and the ADA.

Other Information

In the event of an emergency, whom should we contact?

His/her Name _____ Relationship _____

Work Number _____ Home Number _____

Physician's Name _____ Phone Number _____

Are you currently under the care of a physician? ○ Yes ○ No Please Explain _____

Doctors Notes: