

Welcome



Coach Hill Dental
family and cosmetic dentistry

Please fill out this form completely.

If you have any questions or need assistance, please ask us.

Patient Information *(Confidential)*

Date _____

Name _____ Birthdate (d/m/y) _____

Address _____ City _____ Prov. _____ Postal Code _____

Home Phone _____ Work Phone _____ Cell _____ Email _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

What do we need to know about you to ensure that your visits here are positive experiences? _____

What are your long term goals regarding the condition of your mouth? _____

Has anyone ever recommended pre-medication prior to dental treatment?. Reason _____

What prompted your decision to come here today? _____

How often do you go to the dentist? _____

When was your last oral hygiene appointment? _____

Responsible Party

Name of person responsible for account *(if different from above)* _____

Address *(if different from above)* _____

Phone *(if different from above)* _____

Insurance Information

We will happily complete your claim forms and submit them on your behalf.

We ask that you clear your account at each visit.

PRIMARY

Name of Insured _____ Birthdate (d/m/y) _____

Relationship to Patient _____ Employer _____

Name of Insurance Company _____

Group Policy # _____ Division# _____ ID/Certificate# _____

ADDITIONAL

Name of Insured _____ Birthdate (d/m/y) _____

Relationship to Patient _____ Employer _____

Name of Insurance Company _____

Group Policy # _____ Division# _____ ID/Certificate# _____

Please continue on other side of form...

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

Are you under medical treatment now? Y N
 Have you been hospitalized for any surgical operation or a serious illness within the last 5 years? Y N
 If yes, please explain _____

Are you taking any medication(s) including non-prescription medicine? Y N
 If yes, what medication(s)? _____

Do you use tobacco? Y N
 Do you use controlled substances? Y N
 Are you wearing contact lenses? Y N
 Are you allergic to or have you had any reactions to the following?
 Local Anesthetics (e.g. Novocain) Y N
 Penicillin or any other antibiotics Y N

Sulfa drugs Y N
 Barbiturates Y N
 Sedatives Y N
 Iodine Y N
 Aspirin Y N
 Any metals (e.g. nickel, mercury, etc) Y N
 Latex rubber Y N
 Other (please list) Y N

Do you have a persistent cough or throat clearing not associated with a know illness (lasting more than 3 weeks)? Y N

Women only:
 Are you or do you think you may be pregnant? Y N
 Are you nursing? Y N
 Are you taking any oral contraceptives? Y N

Do you have, or have you had any of the following?

	Y	N		Y	N		Y	N
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Easily Winded	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever / Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Fainting/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Frequently Tired	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement or Implant	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Diseases	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Troubles/Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Other _____		
			Persistent Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Undiagnosed Rash	<input type="checkbox"/>	<input type="checkbox"/>

Patient Dental History

Names of Previous Dentist and Location _____ Date of Last Exam _____

Do your gums bleed during brushing or flossing? Y N
 Are your teeth sensitive to hot or cold liquids/foods? Y N
 Are your teeth sensitive to sweet or sour liquids/foods? Y N
 Do you feel pain in any of your teeth? Y N
 Do you have any sore or lumps in or near your mouth? Y N
 Have you had any head, neck or jaw injuries? Y N
 Have you ever experienced any of the following jaw problems:
 Clicking Y N
 Pain (joint, ear, side of face) Y N
 Difficulty chewing Y N
 Do you have frequent headaches? Y N

Do you clench or grind your teeth? Y N
 Do you bit your lips or cheeks frequently? Y N
 Have you ever had any difficult extractions in the past? Y N
 Have you ever had any prolonged bleeding following extractions? Y N
 Have you had any orthodontic treatment? Y N
 Do you wear dentures or partials? Y N
 If yes, date of placement? _____
 Have you ever received oral hygiene instructions regarding the care of your teeth and gums? Y N
 Do you like your smile? Y N

Authorization and Release: I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependent's.

Signature of patient (or parent/guardian if a minor) _____

Doctor's Comments _____

Signature

Date