IVERSON DENTAL CARE

Patient Information

Patient Name: _____ Date: _____
Last First MI (Preferred Name)

Gender: ☐ Male ☐Female
Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____

Address: _____
Street Apartment#

_____
City State Zip Code

Email Address: _____

Emergency Contact: _____ Phone: _____

Pharmacy: _____ Phone:_____

Preferred Method of Contact: ☐ Email ☐Home Ph. ☐Cell Ph. ☐Work Ph.

Insurance Information

Primary Insurance:

Name: _____ ☐ Same as Above
Last First MI (Preferred Name)

Birth Date: _____ Family Status: _____ Relationship to Patient: _____

Primary Dental Insurance Company: _____

Subscriber ID: _____ Insurance Co. Phone #: _____

Employer Name: _____

Secondary Insurance:

Name: _____ ☐ Same as Above
Last First MI (Preferred Name)

Birth Date: _____ Family Status: _____ Relationship to Patient: _____

Secondary Dental Insurance Company: _____

Subscriber ID: _____ Insurance Co. Phone #: _____

Referral Information

Whom may we thank for referring you to our practice? ☐Another Patient ☐Dental Office
☐Website: _____ ☐ Work ☐ Other: _____

Name of person or office referring you to our practice: _____

Medical Information

Do you have any of the following medical conditions?

Y N	Y N	Y N	Y N
☐☐ AIDS	☐☐ Drug Use	☐☐ Migraine/Headaches	☐☐ Stroke
☐☐Anemia	☐☐ Eating Disorders	☐☐ Pacemaker	☐☐ Tobacco/Vapes/E-Cigarette
☐☐ Arthritis	☐☐ Epilepsy	☐☐ Pregnancy	
☐☐ Artificial Joints: _____	☐☐ Hearing Aids	☐☐ Psychiatric Treatment	
_____	☐☐ Heart Disease	☐☐ Reflux/Gerd	
☐☐ Asthma	☐☐ Heart Murmur	☐☐ Radiation/Chemo Treatment	
☐☐ Blood Disease	☐☐ Hepatitis	☐☐ Respiratory Problems	
☐☐ Cancer: _____	☐☐ HPV	☐☐ Rheumatic Fever	
_____	☐☐ High Blood Pressure	☐☐ Sinus Problems	
☐☐ Diabetes	☐☐ Kidney Disease	☐☐ Sleep Apnea/C-PAP	
☐☐ Dizziness/Vertigo	☐☐ Liver Disease	☐☐ Stomach Problems	

Are you allergic to any of the following?

Y N	Y N
☐☐ Anesthetic	☐☐ Iodine
☐☐ Aspirin	☐☐ Latex
☐☐ Codeine	☐☐ Penicillin
☐☐ Ibuprofen	☐☐ Sulfa

Other: _____

List all medications you are now taking: (If you have list we can scan it)

_____

_____

_____

Do you have to take an antibiotic prior to your dental appointment? ☐Yes ☐No
If yes, please explain: _____

Have you been admitted to a hospital or needed emergency care during the past two years? ☐Yes ☐No
If yes, please explain: _____
Are you now under the care of a physician? ☐Yes ☐No
If yes, please explain: _____
Name of physician: _____ Phone: _____
Do you have any health problems that need further clarification? ☐Yes ☐No
If yes, please explain: _____

Dental History

General Information:

Previous dentist? _____ Date of last dental examination? _____

Do you have any current dental concerns? ☐Yes ☐No
If yes, please explain: _____

Do you feel nervous about dental treatment? ☐Yes ☐No
If so, what can we do to help? _____

Dental Conditions:	Y	N	Details
Do you currently have any dental pain?	☐	☐	_____
Do you have any broken or cracked teeth and/or fillings?	☐	☐	_____
Do you have tooth pain when eating?	☐	☐	_____
Do you have any sensitivity to hot or cold?	☐	☐	_____
Does your food ever get caught between your teeth?	☐	☐	_____
Have you ever had a tooth extracted?	☐	☐	_____
Hygiene Conditions:			
Do your gums bleed when you brush or floss?	☐	☐	_____
Does it hurt when you brush or floss?	☐	☐	_____
Have you been referred to a periodontist or been told you need a "deep cleaning?"	☐	☐	_____
TMJ:			
Do you have any clicking or popping in your jaw joints?	☐	☐	_____
Does your jaw hurt when you eat?	☐	☐	_____
Do you clench or grind your teeth?	☐	☐	_____
Do you wake up with sore jaw muscles?	☐	☐	_____
Do you have a night guard?	☐	☐	_____
Oral Conditions:			
Do you have a bad taste in your mouth?	☐	☐	_____
Have you noticed or have any concerns of bad breath?	☐	☐	_____
Have you experienced dry mouth?	☐	☐	_____
Do you occasionally get ulcers or sores in your mouth?	☐	☐	_____
Do you have any white or red spots in your mouth that do not go away?	☐	☐	_____
Do you have any difficulty chewing or swallowing?	☐	☐	_____
Do you ever have a burning sensation in your mouth?	☐	☐	_____
Cosmetic:			
Are you happy with the appearance of your teeth?	☐	☐	_____
Is there anything about your smile that you would like to change?	☐	☐	_____
Caries Risk/Habits:			
Do you sip on energy drinks, juice or soft drinks throughout the day?	☐	☐	_____
Do you smoke tobacco?	☐	☐	_____
Do you chew tobacco or snuff?	☐	☐	_____
Do you brush your teeth less than twice per day?	☐	☐	_____

Signature: _____ **Date:** _____