RUTHER GLEN DENTAL

Ruther Glen, Virginia

CLEAR FORM

WELCOME TO RUTHER GLEN DENTAL

ABOUT YOU

Name: _____ Date: _____

How did you find out about our dental office? _____

Birth date: _____ Sex: ☐ Male ☐ Female Your social security #: _____

Cell phone: _____ Home phone: _____ Work phone: _____

Email address: _____

Employer: _____

Are you a student? ☐ Yes ☐ No

If yes, name of school/college: _____

Home street address: _____

City: _____ State: _____ Zip: _____

Emergency contact name: _____ Emergency contact phone: _____

How would you like us to confirm future appointments? (check as many as you want)

Text ☐ Email ☐ Phone call ☐

PRIMARY DENTAL INSURANCE

Do you have dental insurance? ☐ Yes ☐ No

Policy holder name (Subscriber): _____

Relationship to patient: _____

Policy holder employer: _____ Insurance co. name: _____

Policy holder policy I.D./No. _____ Group ID/No. _____

Policy holder DOB: _____ Policy holder SS#: _____

Insurance Co. address: _____

_____ Insurance Co. phone: _____

SECONDARY DENTAL INSURANCE

Policy holder name (Subscriber): _____

Relationship to patient: _____

Policy holder employer: _____ Insurance co. name: _____

Policy holder policy I.D./No. _____ Group ID/No. _____

Policy holder DOB: _____ Policy holder SS#: _____

Insurance Co. address: _____

_____ Insurance Co. phone: _____

ASSIGNMENT AND RELEASE

I authorize the doctor to release all information necessary to secure the payment of benefits.
I authorize the use of this signature on all my insurance submission whether manual or electronic.

Signature: _____ Date: _____

DENTAL HEALTH HISTORY

Name: _____

What would you like done on your first visit with us?

_____

_____

Any problems, pain or emergencies in any part of your mouth or teeth?

_____

_____

Approximate date of last dental visit: _____ Date of your last X-rays (if known): _____

Would you like us to get your dental records from your previous dentist? ☐ Yes ☐ No

If yes, give us the name and address of the dentist:

_____

_____

	X if yes	Details:
Are you apprehensive about dental treatment?	☐	_____
Have you had problems with previous dentistry?	☐	_____
Do you gag easily?	☐	_____
Do you have any difficulty chewing your food?	☐	_____
Do you chew on only one side of your mouth?	☐	_____
Is there any bleeding in your gums?	☐	_____
Do your gums feel swollen or tender?	☐	_____
Are your teeth sensitive to hot, cold, sweets, etc?	☐	_____
Have you ever had a toothache?	☐	_____
Are there any problems with your jaw, such as pain, getting stuck, inability to open wide, popping noises, etc?	☐	_____
Have you been told you had a temporomandibular (jaw) disorder (TMD or TMJ)?	☐	_____ _____
Is there any clicking or popping of your jaw?	☐	_____
Have you ever had orthodontic treatment?	☐	_____
Would you like to keep all your natural teeth for life?	☐	_____
Have you ever had gum bleeding or inflammation due to crowding teeth (teeth too close together)?	☐	_____

Is there anything you would like to change or improve about the appearance of your smile?

_____

_____

_____

_____

MEDICAL HEALTH HISTORY

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

X if yes

Heart problems
- Chest pain ☐
- Shortness of breath ☐
- High blood pressure ☐
- Heart murmur ☐
- Pacemaker ☐
- Rheumatic fever ☐
- Artificial heart valve ☐

Blood problems
- Easy bruising ☐
- Frequent nosebleeds ☐
- Abnormal bleeding ☐
- Blood disease ☐
- Ever had a blood transfusion? ☐

Allergies
- Hay fever ☐
- Sinus problems ☐
- Skin rashes ☐
- Asthma ☐

Intestinal problems
- Ulcers ☐
- Weight gain or loss ☐
- Special diet ☐
- Constipation/diarrhea ☐
- Kidney/bladder problems ☐

Bone or joint problems
- Arthritis ☐
- Back of neck pain ☐
- Joint replacement ☐
- Fainting spells, seizures or epilepsy ☐
- Stroke ☐
- Frequent or severe headaches ☐
- Persistent cough or swollen glands ☐
- Cancer/tumor ☐
- Diabetes ☐
- Turberculosis/respiratory disease ☐
- Hepatitis, jaundice or liver troubles ☐
- Herpes or other STD ☐
- HIV-positive/AIDS ☐
- Glaucoma ☐
- Drug or alcohol dependence ☐

Any other disease or condition we should know about?

_____

_____

_____

_____

Are you now taking, or during the past 12 months have you taken, any of the following?

X if yes

- Antibiotics or sulfa drugs ☐
- Anticoagulants (like Coumadin) ☐
- Tranquilizers ☐
- Insulin, orinase or similar drug ☐
- Digitalis/heart medications ☐
- Nitroglycerin ☐
- Cortisone/steroids ☐
- Non-prescription drugs ☐
- Natural remedies ☐

List other medications/drugs you are taking:

_____

_____

Are you allergic, or have you had an adverse reaction to, any of the following:

- Local anesthestics (Novocaine, etc.) ☐
- Penicillin or other antibiotics ☐
- Sulfa drugs ☐
- Barbiturates, sedatives or sleeping pills ☐
- Aspirin, acetaminophen or Ibuprofen ☐
- Codeine, demerol or other narcotics ☐
- Epinephrine ☐
- Metals (gold, silver, etc) ☐
- Latex ☐
- Other ☐

Women

Contraceptives or other hormones you are taking:

_____

_____

_____

Are you pregnant? ☐

If yes, expected delivery date: _____

Are you nursing? ☐

Have you reached menopause? ☐

If so, do you have any symptoms?

_____

_____

_____

Is there any disease, condition, surgery or problem not listed above we should know about?

_____

_____

_____

_____

_____

_____

_____

MEDICAL HEALTH HISTORY

Are you now under a physician's care? ☐ Yes ☐ No
If yes, for what?

_____

_____

Your physician's name: _____ Your physician's phone: _____

Do you smoke or chew tobacco? ☐ Yes ☐ No

To the best of my knowledge, all of the previous answers are true and correct. If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment. Should further information be needed, Ruther Glen Dental and Dr. Johnson have my permission and authorization to ask the appropriate health care providers or agencies, who may release such information to you.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN:

_____

DATE: _____