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Thank You For Selecting Clark General & Implant Dentistry

Patient Information

Patient Number ______________

Name ______________ Date ______________

SS#/SIN ______________ Birthday ______________ Home Phone ______________

Address ______________ City ______________ State/Prov. ______________

Email ______________ Cell Phone ______________

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Full Time

If Student, Name of School/College ______________ City ______________ State/Prov. ______ ☐ Part Time

Patient or Parent/Guardian's Employer ______________ Work Phone ______________

Business Address ______________ City ______________ State/Prov. ______ Zip/PC ______

Spouse or Parent/Guardian's Name ______________ Employer ______________ Work Phone ______________

Whom May We Thank For Referring You? ______________

Person to Contact in Case of Emergency ______________ Phone ______________

Responsible Party

Name of Person Responsible for this Account ______________ Relationship ______________

Address ______________ Home Phone ______________

Email ______________ Cell Phone ______________

Drivers License # ______________ Birthday ______________ Financial Institution ______________

Employer ______________ Work Phone ______________ SS#/SIN ______________

Is this Person Currently a Patient in our Office ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment

☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ MasterCard ☐ Office Payment Plan

Insurance Information

Name of Insured ______________ Relationship ______________

Birthdate ______________ SS#.SIN ______________ Date Employed ______________

Name of Employer ______________ Union/Local# ______ Work Phone ______________

Employer Address ______________ City ______________ State/Prov. ______ Zip ______

Insurance Company ______________ Group# ______________ Policy ID# ______________

Ins. Co. Address ______________ City ______________ State/Prov. ______ Zip ______

How Much is Your Deductible? ______ How Much Have You Used? ______ Max. Annual Benefit? ______

Do You Have Any Additional Insurance? ☐ Yes ☐ No If Yes, Complete the Following

Name of Insured ______________ Relationship ______________

Birthdate ______________ SS#/SIN ______________ Date Employed ______________

Name of Employer ______________ Union/Local# ______ Work Phone ______________

Employer Address ______________ City ______________ State/Prov. ______ Zip ______

Insurance Company ______________ Group# ______________ Policy ID# ______________

Ins. Co. Address ______________ City ______________ State/Prov. ______ Zip ______

How Much is Your Deductible? ______ How Much Have You Used? ______ Max. Annual Benefit? ______

Please Turn Over

Patient Medical History

Form 166240

Physician ______________ Office Phone ______________ Date of Last Exam ______________

Question	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain ______________	☐	☐
3.Are you taking any medication(s) including non-prescription medicine? If yes, which medication(s) are you taking? ______________	☐	☐
4. Have you ever taken Phen-Fen/Redux?	☐	☐
5. Do you use tobacco?	☐	☐
6. Do you use controlled substances?	☐	☐
7. Are you wearing contact lenses?	☐	☐
8. Do you have or have you had any of the following?	☐	☐

9. Are you allergic to or have you had any reactions to:	Yes	No
Local Anaesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other ______________	☐	☐
10. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)	☐	☐
11. For Women Only:		
Are you pregnant or think you may be pregnant?	☐	☐
Are you nursing?	☐	☐
Are you taking oral contraceptives?	☐	☐

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐	Recent Weight Loss	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐	Liver Disease	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐	Heart Trouble	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies	☐	☐	Respiratory Problems	☐	☐
Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐	Mitral Valve Prolapse	☐	☐
Asthma	☐	☐	Anaemia	☐	☐	Radiation Therapy	☐	☐	Hepatitis / Jaundice	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Kidney Diseases	☐	☐	Sexually Transmitted Disease	☐	☐
Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	AIDS or HIV Infection	☐	☐	Stomach Troubles / Ulcers	☐	☐
Leukaemia	☐	☐	Arthritis	☐	☐	Thyroid Problem	☐	☐	Other ______________	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Glaucoma	☐	☐			

Patient Dental History

Name of Previous Dentist ______________ Dentist's Location ______________ Date of Last Exam ______________ Date of Last Cleaning ______________

Question	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following	☐	☐
8. Do you have or have you had any of the following?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

Question	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had prolonged bleeding after extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, date of placement ______________		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

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 Clark General & Implant Dentistry to authorize my information including the diagnosis and the records of any treatment of examination rendered to me or my child during the period of such dental care to third party players and/or health practitioners. I authorize and request my insurance company to pay directly to Clark General & Implant Dentistry 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 dependants.

____
Signature of patient (or parent/guardian of minor)

Doctor's Comments

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____

Signature Date