DAVID W. MAXWELL, DMD

PATIENT INFORMATION

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name ______________ M.I. ______ Last Name ______________

Nickname: ______________

Sex: ❑ Male ❑ Female Birth Date ________ Age ______ Soc. Sec. # ______________

Street ______________ City ______________ State ________ Zip ________

Home Tel. ________ Cell. ________ Work ________ Employer ______________

Email ______________ Emergency Contact ______________ Tel. ______________

General Dentist ______________ Tel. ________ If Greenberg or Coast, which location ________

Who will be responsible for your account? ❑ Self (if self, skip to next section) ❑ Spouse ❑ Parent ❑ Other ________

First Name ______________ M.I. ______ Last Name ______________ Soc. Sec. # ________

Street ______________ City ______________ State ________ Zip ________

Home Tel. ________ Cell. ________ Work ________ Employer ______________

DENTAL INSURANCE INFORMATION

Primary Insurance Company ______________ Tel. ________ ❑ DMO/HMO ❑ PPO

Group # ______________ Group Name ______________ Subscriber ID # ______________

(if other than patient) Insured Party's First Name ______________ Last Name ______________ Relation ________

Street ______________ City ______________ State ________ Zip ________

Birth Date ________ Soc. Sec. # ________ Tel. ________ Employer ______________

MEDICAL HISTORY

Have you had or do you currently have:

Fibromyalgia	❑ Yes ❑ No	HIV	❑ Yes ❑ No	Cancer	❑ Yes ❑ No
Heart Murmur / Mitral Valve Prolapse	❑ Yes ❑ No	Angina/Heart Attack	❑ Yes ❑ No	Stroke	❑ Yes ❑ No
Heart Valve / Joint Replacement	❑ Yes ❑ No	Pacemaker	❑ Yes ❑ No	Epilepsy	❑ Yes ❑ No
Rheumatic Fever	❑ Yes ❑ No	High Blood Pressure	❑ Yes ❑ No	Asthma	❑ Yes ❑ No
Diabetes	❑ Yes ❑ No	Kidney Disease	❑ Yes ❑ No	Sinus Problems	❑ Yes ❑ No
Hepatitis / Liver Disease	❑ Yes ❑ No	Thyroid Disease	❑ Yes ❑ No	Substance Abuse	❑ Yes ❑ No
Irritable Bowel / Ulcerative Colitis	❑ Yes ❑ No	Bruising / Bleeding Problems	❑ Yes ❑ No	Mental Health Prob	❑ Yes ❑ No
Penicillin Allergy	❑ Yes ❑ No	Stomach Ulcers	❑ Yes ❑ No	Other Condition	❑ Yes ❑ No
Latex Allergy	❑ Yes ❑ No	Tuberculosis / Lung Problem	❑ Yes ❑ No		

Has your physician/cardiologist instructed you to premedicate with antibiotics prior to a dental appointment? ❑ Yes ❑ No

If yes to any, please explain: ______________

Are you currently Pregnant or Nursing: ❑ Yes ❑ No

Medications presently taking (bone density medications, bisphosphonates, blood thinners, vitamins, supplements, others):

____

Allergic to any drugs or medications: ______________

I certify that the above information is correct:

______________________________ ______________

Patient Signature (or guardian of a minor) Date

PATIENT'S DENTAL HISTORY

PATIENT'S NAME ______________________________ DATE OF BIRTH ______________

REASON FOR THIS VISIT ______________________________

WHEN WAS YOUR LAST DENTAL VISIT ______________ WHAT WAS DONE THEN ______________

HOW OFTEN DID YOU VISIT THE DENTIST BEFORE THEN ______________________________

PREVIOUS DENTIST (NAME AND LOCATION) ______________________________

HAVE YOU HAD A COMPLETE SERIES OF DENTAL FILMS (X-RAYS) TAKEN WHEN/WHERE ______________

HOW OFTEN DO YOU BRUSH YOUR TEETH ______________ HOW OFTEN DO YOU FLOSS YOUR TEETH ______________

IS YOUR DRINKING WATER FLUORIDATED ______________________________

	YES	NO
DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING	☐	☐
ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS	☐	☐
ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS	☐	☐
DO YOU FEEL PAIN TO ANY OF YOUR TEETH	☐	☐
DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH	☐	☐
HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES	☐	☐
HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?		
CLICKING	☐	☐
PAIN (JOINT, EAR, SIDE OF FACE)	☐	☐
DIFFICULTY IN OPENING OR CLOSING	☐	☐
DIFFICULTY IN CHEWING	☐	☐
DO YOU HAVE FREQUENT HEADACHES	☐	☐
DO YOU CLENCH OR GRIND YOUR TEETH	☐	☐
DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY	☐	☐
HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH	☐	☐
DOES FOOD TEND TO BECOME CAUGHT BETWEEN YOUR TEETH	☐	☐
HAVE YOU EVER HAD PERIODONTAL TREATMENT (GUMS)	☐	☐
EVER WORN A BITE PLATE OR OTHER APPLIANCE	☐	☐
HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST	☐	☐
HAVE YOU EVER HAD ANY PROLONGED BLEEDING FOLLOWING EXTRACTIONS	☐	☐
DO YOU WEAR DENTURES OR PARTIALS	☐	☐
IF YES, DATE OF PLACEMENT ______________		
HAVE YOU EVER RECEIVED ORAL HYGIENE INSTRUCTIONS REGARDING THE CARE OF YOUR TEETH AND GUMS	☐	☐

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE? ______________________________

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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 DEPENDENTS.

X ______________________________ DATE ______________

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

DOCTOR'S COMMENTS ______________________________

____

______________ SIGNATURE ______________________________ DATE ______________

PATIENT'S NUMBER ______________