



Welcome to our office. It is our sincere hope that your visits here will be comfortable and satisfying. Please take a few minutes to complete this confidential questionnaire so that we may better serve you.
Sherwood Old Town Dental

PATIENT INFORMATION

Patient name _____ Prefer to be addressed as _____
 Date of birth _____ Sex _____ Marital Status _____ SSN _____ Drivers Lisc: _____
 Home address _____
 City/State _____ Zip _____ Home Phone _____
 Employer _____ Work Phone _____ May we call you at work? _____
 Email address _____ Cell phone _____
 Pharmacy name/location _____ Phone _____
 Preferred method of contact? Home phone _____ Work phone _____ Email _____ Cell phone _____
 Student _____ Where? _____ **Whom may we thank for this referral?** _____
 Nearest relative not living with you _____ relationship _____ phone _____

Guarantor (if not same as above) – Please note: we cannot bill a non-custodial parent

Name _____ Relationship _____
 Date of birth _____ SSN # _____ Drivers License _____
 Billing address _____
 City/State _____ Zip _____ Home Phone# _____
 Employer _____ Work Phone _____ May we call you at work? _____

Insurance

Primary

Secondary

Insurance Co. Name	_____	_____
Insurance Billing Address	_____	_____
Insurance Telephone	_____	_____
Insurance Group #	_____	_____
Insurance ID #	_____	_____
Insurance Claims Address	_____	_____
Policyholder's Name	_____	_____
Relationship to Patient	_____	_____
Policyholder's DOB	_____	_____
Policyholder's Employer	_____	_____

I hereby authorize Sherwood Old Town Dental to furnish information to insurance carries concerning my dental condition and treatments and I hereby assign to them all payments for dental services to myself or my dependants. I understand that I am responsible for all fees regardless of insurance coverage.

Policyholder Signature _____ Date _____

I ACKNOWLEDGE THAT I REVIEWED THE POSTED OFFICE PRIVACY POLICY NOTICE. I AGREE TO PAY FOR SERVICES AS THEY ARE RENDERED. IF PROCEDURES ARE COVERED IN WHOLE OR IN PART BY DENTAL INSURANCE, I AUTHORIZE PAYMENT TO SHERWOOD OLD TOWN DENTAL. INSURANCE BENEFIT ESTIMATES MAY BE INCORRECT. ANY AND ALL BALANCES WILL BE MY RESPONSIBILITY, IN ACCORDANCE WITH SHERWOOD OLD TOWN DENTAL CREDIT POLICY (AVAILABLE ON REQUEST).

SIGNATURE

DATE

MEDICAL HISTORY

Do you have a personal physician? Y N
 Are you currently under a physician's care? Y N
 Physician's name: _____
 Phone: _____ Date of last visit: _____
 Reason for last physician visit: _____

YOUR CURRENT PHYSICAL HEALTH IS:

Good	Fair	Poor	
Do you smoke or use tobacco in any form?			Y N
Are you using any of the following?			

- Antibiotics?
- Anticoagulants (Blood Thinners)?
- Aspirin or drugs such as Motrin, Aleve, Ibuprofen?
- High Blood Pressure medications?
- Steroids (Cortisone, etc.)?
- Bisphosphonate (Fosamax, Boniva, Actonel)?
- Tranquilizers?
- Digitalis, Inderal, Nitroglycerin or other heart drug?

Please list any and all medications taken, including prescription medication, over-the-counter medications, herbal or holistic remedies, vitamins or minerals: _____

FOR WOMEN: Are you taking birth control pills? Y N
 Are you pregnant? Y N Week _____
 Are you nursing? Y N

Have you ever had any of the following diseases or medical problems:

- | | |
|------------------------------|---------------------------|
| Y N Alcohol/Drug Abuse | Y N Hepatitis |
| Y N Anemia | Y N Herpes/Fever Blisters |
| Y N Arthritis | Y N High Blood Pressure |
| Y N Artificial Joints/Valves | Y N HIV+/AIDS |
| Y N Asthma | Y N Hospitalization |
| Y N Bleeding Problems | Y N Kidney Problems |
| Y N Blood Transfusion | Y N Liver Disease |
| Y N Cancer/Chemotherapy | Y N Low Blood Pressure |
| Y N Congenital Heart Defect | Y N Mitral Valve Prolapse |
| Y N Diabetes | Y N Pacemaker |
| Y N Difficulty Breathing | Y N Psychiatric Problems |
| Y N Emphysema | Y N Radiation Treatment |
| Y N Epilepsy | Y N Rheumatic Fever |
| Y N Fainting/Dizzy Spells | Y N Seizures |
| Y N Frequent Headaches | Y N Shingles |
| Y N Heart Attack | Y N Sickle Cell Trait |
| Y N Heart Murmur | Y N Sinus Problems |
| Y N Heart Surgery | Y N Stroke |
| Y N Hemophilia | Y N Ulcers |

Please list any other serious medical condition (s) that you have had which are not listed above: _____

Are you Allergic to any of the following? (Please circle all that apply)

- | | | |
|--------------|--------------------|--------|
| Aspirin | Erythromycin | Metals |
| Codeine | Penicillin | Latex |
| Tetracycline | Dental Anesthetics | Sulfa |

Please list any other drugs/materials that you are allergic to: _____

DENTAL HISTORY

What is the primary reason for your visit to our practice today?

Are you currently in pain? Y N
 Do you require antibiotics before dental treatment? Y N

YOUR CURRENT DENTAL HEALTH IS:

Good	Fair	Poor
When was the last time you had a complete dental evaluation? _____		

Have you ever had a serious/difficult problem associated with any previous dental work? Y N
 Do you floss regularly? Y N
 How often do you brush? _____

Have you been informed or treated for the following dental conditions?

Y N Bleeding Gums	Y N Mobility of Teeth
Y N Bad Taste/Odor	Y N Oral Cancer/Biopsy
Y N Cold Sores/Ulcers	Y N Osseous Surgery
Y N Deep Cleanings/Scaling	Y N TMJ/TMD Joint Pain
Y N Gum/Periodontal Disease	Y N Tooth brush Abrasion
Y N Hot/Cold Sensitivity	Y N Wisdom

Would you like fresher breath? Y N
 Are you happy with the way your smile looks? Y N
 If not, what would you change? _____

I understand that the information I have given today is correct and accurate to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I hereby authorize treatment and the use of nitrous oxide, anesthesia, oral sedation and/or other medications necessary for dental treatment to be rendered by the dental staff.

Patient's (parent) Signature _____ Date _____

DOCTORS COMMENTS/NOTES: _____

I verbally reviews the medical/dental information with the patient (parent) named herein.

Reviewer's Signature _____ Date _____