Pederson Bilben
FAMILY DENTAL

We are pleased to welcome you to our practice.
Please fill out this form as completely as possible.

Patient's Name _____ *Phone* _____
Address _____ *Cell Phone* _____
*Birth Date*_____ ◯*Single* ◯*Married* ◯*Widowed* ◯*Partner* ◯*Separated* ◯*Divorced*
Employer _____ *Occupation* _____
Business Address _____ *Phone* _____
Person Responsible for Account _____
Address _____ *Phone* _____
Employer _____ *Business Phone* _____
Business Address _____ *Cell Phone* _____
Dental Insurance Company _____ *Group #*_____
Insurance Company Address _____
Subscriber's Name _____ *ID #* _____
Subscriber's Birth Date _____ *Subscriber's SS #* _____
Whom May We Thank For Referring You? _____

Dental History

Dental Problems or Concerns Today _____
In Case of Emergency, Who Should We Contact? _____
Date of Last Dental Visit _____ *Date of Last Dental X-rays* _____

Do You Have or Use Any of the Following – Please Check

___ Tooth Pain
___ Sensitive Teeth/Hot, Cold or Sweets
___ Swelling or Lumps in Mouth
___ Bleeding Gums
___ Clenching or Grinding Teeth
___ Mouth Breathing
___ Traumatic Injury to Head, Jaw or Teeth
___ Bad Breath
___ Oral Habits: Nail or Lip/Cheek Biting
___ Orthodontic Treatment
___ Periodontal Treatment
___ Loose Teeth or Broken Fillings
___ Jaw Clicking or Pain
___ Frequent Headaches
___ Dental Floss/Frequency _____
___ Toothbrush/Frequency _____

I have reviewed the information on these forms, and it is accurate to the best of my knowledge. Payment is due in full at time of treatment, unless prior arrangements have been made or insurance information has been given. Patient is responsible for balance not paid by insurance and authorizes payment to be made to the dentist for all insurance submissions. I agree to pay a finance charge of 1.5% per month after 60 days on any unpaid balance.

Signature _____***Date*** _____

Medical History

Patient's Name _____ Phone _____

Medical Doctor or Clinic _____ Date of Last Appt _____

Do You Have or Have You Had Any of the Following – Please Check

___ Allergy to Anesthetic
___ Material Allergies (latex,metal,chemicals)
___ Heart Problems/Describe _____
___ Heart Attack/Stroke
___ High/Low Blood Pressure
___ Heart Murmur/Mitral Valve Prolapse
___ Artificial Heart Valves
___ Pacemaker
___ Cancer/Radiation Treatment/Chemotherapy
___ Diabetes/Hypoglycemia
___ Anemia/Blood Disorder/Hemophilia
___ Excessive Bleeding from a Cut
___ Kidney Disease or Problems
___ Tuberculosis
___ Ulcer/Colitis
___ Fainting/Dizziness
___ Convulsions/Epilepsy
___ Osteopenia/Osteoporosis
___ Artificial Joints/Describe _____
___ Back Problems
___ Arthritis/Rheumatism
___ Liver Disease /Jaundice
___ Hepatitis-Type _____
___ Herpes/Venereal Disease
___ Immune System Disorder (AIDS,ARC,HIV)
___ Headaches/Migraines
___ Cortisone Treatments
___ Asthma
___ Hay Fever or General Allergies
___ Respiratory Disease
___ Sinus Problems
___ Emphysema
___ Thyroid Disease/Disorder
___ Rheumatic/Scarlet Fever
___ Nervous Disorder/Problems
___ Psychiatric Care
___ Chemical Dependency
___ Use Tobacco Products
___ Food Allergies _____
___ Eye/Glaucoma Problems
___ Facial/Head Injuries
___ Women: Are You Pregnant

List Any Medications You are Taking

_____
_____
_____

List Any Drug or Medication Allergies

_____
_____
_____

Patient Signature _____ Date _____

SUBMIT FORM

Medical Update

I Have Reviewed My Health History & Confirm that it Accurately States Past & Present Conditions

Date	Signature	Changes to Health History	Initials Dentist/Hygienist
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____