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Confidential Information - Please complete, sign, date, and return by fax or mail prior to appointment.

Adult Patient Information- Age 14 and older

Name _____ _____ Male ☐ Female ☐
First Middle Last Preferred Name
Address _____ City _____ State_____ Zip _____
Home Phone _____ Cell Phone_____ Business Phone_____
Date of Birth _____ Occupation _____ Employer _____
Social Security # _____ Email _____ Name of Spouse_____
Person to contact for emergency _____ Relationship_____ Phone _____
Name of other family members who are patients in our office _____
Whom may we thank for referring you to our office? _____

Responsible Party Information (if different from above)

Name _____ Relationship to Patient _____
Address _____ **City** _____ State _____ Zip _____
Home Phone _____ Date of Birth_____ Social Security #_____
Employer _____ Address _____
Business Phone _____ Cell Phone: _____

Dental Insurance Information

Primary Ins. Name of Policy Holder _____ Date of Birth _____
Social Security # _____ NAME OF EMPLOYER _____
Dental Insurance Co. _____ Group # _____ Insurance ID#_____
Address _____ City _____ State _____ Zip _____
Effective Date _____ Insurance Phone # _____

Secondary Ins Name of Policy Holder _____ Date of Birth _____
Social Security # _____ NAME OF EMPLOYER _____
Dental Insurance Co. _____ Group # _____ Insurance ID#_____
Address _____ City _____ State _____ Zip _____
Effective Date _____ Insurance Phone # _____

I grant the right to Philip E Strevey, DDS, FAGD to release my information about my dental treatment to third party payors and/or health professionals. I understand that I am financially responsible for all charges whether or not paid by insurance. / authorize the use of this signature on all insurance submissions.

x_____ **Date:** _____
Signature of Patient or Responsible Party

PLEASE SIGN AND COMPLETE ALL 3 PAGES

ADULT MEDICAL INFORMATION AGE 14 AND OLDER

Patient Name _____

Overall Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Have there been any changes in your general health in the past year? ☐ Yes ☐ No

If yes, what were the changes? _____

Date of last complete physical _____ Name of Physician _____

Have you ever been diagnosed with Mitral Valve Prolapse? ☐Yes ☐ No

Have you ever had an artificial joint or heart valve replacement? ☐Yes ☐ No

Have you ever had Rheumatic Fever or Rheumatic Heart Disease? ☐ Yes ☐ No

Have you ever taken Fen-Phen? ☐ Yes ☐ No Redux? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No If yes, how much, and for how long? _____

If yes, would you like help quitting? ☐Yes ☐ No

ARE YOU PREGNANT? YES ☐ NO ☐ Are you taking a birth control pill? YES ☐ NO ☐

ARE YOU OR HAVE YOU EVER TAKEN BISPHOSPHONATES FOR OSTEOPOROSIS? YES ☐ NO ☐

DO YOU HAVE OR EVER HAD ANY OF THE FOLLOWING CONDITIONS? (Please mark boxes that apply)

☐ Heart Disease or Attack	☐ Hepatitis A or B or C	☐ Multiple Sclerosis	☐ Thyroid Condition
☐ Heart Murmur or Pacemaker	☐ HIV + or AIDS	☐ Tumor or Cancer	☐ Tuberculosis
☐ High or Low Blood Pressure	☐ Cold sores of Fever blisters	☐ Hives or Skin Rash	☐ Ulcers
☐ Kidney Disease	☐ Hay Fever	☐ Suppressed/Immune Deficiency	☐ Nervous Disorder
☐ Liver Disease	☐ Headaches	☐ Epilepsy	☐ Psychiatric Treatment
☐ Anemia	☐ Fainting or Dizziness	☐ Persistent Cough	☐ Diabetes
☐ Asthma	☐ Stroke	☐ Latex Allergy	☐ Glaucoma
☐ Arthritis	☐ Hearing Problems	☐ Chronic Pain	☐ Joint Replacement
☐ Gastrointestinal Disorders	☐ Blood Disorders	☐ Lung Disease	

☐ Other conditions not listed ... Please list: _____

IF YOU MARKED ANY OF THE ABOVE, PLEASE EXPLAIN:

_____

_____

_____

_____

PLEASE LIST ALL PRESCRIPTION AND OVER-THE-COUNTER MEDICATIONS YOU ARE TAKING:

_____ Reason: _____

_____ Reason: _____

_____ Reason: _____

_____ Reason: _____

_____ Reason: _____

_____ Reason: _____

PLEASE LIST THE VITAMIN & NUTRITIONAL SUPPLEMENTS YOU ARE TAKING:

_____

_____

_____

PLEASE LIST ALL KNOWN ALLERGIES:

_____

_____

ADULT DENTAL HISTORY AGE 14 AND OLDER

Patient Name_____

Do you have any existing fillings? Yes ☐ No ☐

If yes, are these 'first-time' fillings? Yes ☐ No ☐ If no, have they been filled more than once? Yes ☐ No ☐

Has anyone ever helped you develop a plan to help you keep your teeth for your lifetime? Yes ☐ No ☐

If no, would you like to do this? Yes ☐ No ☐

Have you ever had any negative dental experiences? Yes ☐ No ☐ If yes, please explain. _____

Have your parents experienced gum disease? ☐ Yes ☐ No Tooth loss? ☐ Yes ☐ No Explain:

Do you or have you taken a pre-medication before dental work? Yes ☐ No ☐

If yes, state reason and medication i.e., Joint Replacement, Heart Murmur, Mitral Valve Prolapse, Anxiety

Do you like the appearance of your teeth? Yes ☐ No ☐ If no, why not: _____

Have you ever had braces? Yes ☐ No ☐ If yes, when_____ For how long: _____Reason_____

What would you change about your mouth, or smile, if you could?

Do you have a problem with: (please mark all that apply)

☐ Frequent headaches ☐ Jaw pain ☐ Ringing in your ears ☐ Jaw joint 'noises'

☐ Dry mouth ☐ Bleeding gums ☐ Wisdom teeth ☐ Clenching or Grinding your teeth

Have you ever worn a mouth 'night guard' or 'splint'? Yes ☐ No ☐ If yes, when? _____

Reason _____

Do you currently have any pain or sensitivity? Yes ☐ No ☐ If yes, please describe

Date of your last dental visit: _____Reason _____

May we obtain your former dental history and X-Rays? Yes ☐ No ☐

Name of Previous Dentist: _____Location:_____

Why did you leave your last dentist?

Is there any other information that we need to know or that you would like to share with us regarding your needs and our care for you?

What is the reason for your visit? _____

What are your 'oral health' goals?

I verify that all personal, medical, and dental information is correct,

SIGNATURE Date:

(If under 18 years of age, Signature of Parent or Guardian Required)

***To comply with HIPAA regulations and protect your privacy, completed and signed health forms cannot be returned by email but must be returned by fax, postal mail, or in person preferably prior to day of appointment. Thank you. 9/2/08