



Alpine Dentistry

PATIENT INFORMATION

Welcome to Alpine Dentistry! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Patient's name _____	Preferred name _____	Birth date _____
Preferred phone _____	Email Address _____	
Mailing address _____	City _____	State _____ Zip _____
Employer _____	Occupation _____	
Spouse's name _____	Spouse's employer _____	<input type="checkbox"/> Unmarried
Whom may we thank for referring you to our office? _____		
Emergency Contact & phone number: _____		
BILLING, CREDIT, AND INSURANCE INFORMATION: <input type="checkbox"/> Not covered by dental insurance		
Your Social Security number: _____	Dental Insurance Co. _____	Group number _____
Covered by spouse's insurance? <input type="checkbox"/> yes <input type="checkbox"/> no		
Spouse's dental insurance company _____	Group number _____	
Spouse's birthday _____	Social Security number _____	

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?

(Please check any that apply)

- Cancer or tumor
- Heart murmur, mitral valve prolapse, heart defect
- Artificial joint or heart valve.
Year placed: _____
- High or low blood pressure
- Tuberculosis or other lung problems
- Kidney disease
- Hepatitis or other liver disease
- Alcoholism
- Diabetes
- Epilepsy, seizures, or fainting spells
- Herpes or cold sores
- AIDS or HIV positive
- Migraine headaches or frequent headaches
- Anemia or blood disorders
- Abnormal bleeding after extractions, surgery, or trauma
- Hayfever or sinus trouble
- Allergies or hives
- Asthma

Do you smoke or use chewing tobacco? yes no

How often: _____

Are you allergic to, or have you reacted adversely to any of the following?

- Latex materials
- Penicillin or other antibiotics
- Local anesthetics ("Novocain")
- Codeine or other narcotics
- Sulfa drugs
- Barbiturates, sedatives, or sleeping pills
- Aspirin
- Other: _____

Are you taking any of the following?

- Aspirin
- Anticoagulants (blood thinners)
- Antibiotics or sulfa drugs
- High blood pressure medicine
- Antidepressants or tranquilizers
- Insulin, Orinase, or other diabetes drug
- Nitroglycerin
- Cortisone or other steroids
- Osteoporosis (bone density) medicine
- Other: _____

Women:

- May be pregnant

Expected delivery date: _____

Name of your physician: _____

Do you have any disease, condition, or problem not listed above? _____

Please add anything else you would like us to know about: _____

DENTAL HEALTH

WHAT IS THE REASON FOR YOUR VISIT TODAY? _____

Date (estimate) of last dental visit _____

Date (estimate) of last dental x-rays _____

How often do you floss? _____

How often do you brush? _____

Please check if you have any of the following:

- Bad Breath
- Bleeding Gums
- Blisters on lips or mouth
- Burning sensation on tongue
- Difficulty Chewing
- Clicking or popping jaw
- Dry mouth
- Food collection between the teeth
- Grinding or clenching teeth
- Gums swollen or tender
- Loose teeth
- Broken teeth or fillings
- Mouth pain
- Current orthodontic treatment
- Sensitivity to cold, heat, or sweets
- Sensitivity when biting
- Sores or growths in mouth

Thank you! We look forward to serving you.

Signature of patient (or parent) _____