Natural Dentistry

Is Health Dentistry

Great Smiles Naturally!

Welcome

We are pleased to welcome you to Dr. Carlson's. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient information

Name _____ Social Security # _____

Address _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ Email _____

Sex M or F: _____ Birth date _____ Single, Married, Widowed, Separated, Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business phone _____

Whom may we thank for referring you: _____

Notify in case of emergency _____ Relationship _____

Phone _____ Work phone _____ Cell phone _____

Dependent Children: must be accompanied by a parent or guardian. Adult accompanying child to dental appointment is responsible for payment at time of visit unless prior arrangements have been made.

Primary Insurance

Name _____ Social Security # _____

Relation to Patient _____ Birthdate _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Business Phone _____

Employer _____ Insurance Carrier _____

Group# _____ Subscriber# _____ Phone _____ Payor ID# _____

Circle Y for yes or N for no if you have or have not had the following:

Y or N Bad breath
Y or N Sensitivity to sweets
Y or N Sensitivity to cold
Y or N Sensitivity to hot
Y or N Food collection between teeth
Y or N Bleeding gums
Y or N Sensitivity when biting
Y or N Sores or growths in mouth
Y or N Periodontal treatment
Y or N Grinding or clenching teeth
Y or N Clicking or popping jaw
Y or N Loose teeth/ broken fillings

How often do you brush? _____ How often do you floss? _____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? _____

Medical History

Primary Physician's name _____ Phone _____ Date of last visit _____

Specialist name _____ Phone _____ Date of last visit _____

Have you had any serious illnesses or operations? Y or N if yes, describe _____

Are you currently under a physician's care? Y or N if yes, describe _____

Have you ever had a blood transfusion? Y or N if yes, give approx dates _____

Have you ever taken Fen-Phen/Redux? Y or N

Women: Are you pregnant? Y or N Nursing? Y or N Taking birth control pills? Y or N

Have you ever taken bisphosphonates? (Fosamax, Actonel, Boniva) Y or N

Circle Y for yes or N for no if you have or have not had the following:

Y or N AIDS/HIV Positive
Y or N Anaphylaxis
Y or N Anemia
Y or N Arthritis, Rheumatism
Y or N Artificial heart valves
Y or N Artificial joints
Y or N Asthma
Y or N Atopic (allergy prone)
Y or N Back problems
Y or N Blood disease
Y or N Cancer
Y or N Chemical dependency
Y or N Chemotherapy
Y or N Chest Pain
Y or N Circulatory problems
Y or N Cortisone treatment
Y or N Cough, persistent
Y or N Cough up blood
Y or N Diabetes Type 1 or 2
Y or N Epilepsy or seizures
Y or N Fainting
Y or N Food allergies
Y or N Glaucoma
Y or N Headaches or migraines
Y or N Heart murmur
Y or N Heart problems
Y or N Hemophilia/Abnormal bleeding
Y or N Herpes
Y or N Hepatitis A B C
Y or N High blood pre~sure
Y or N Jaw pain
Y or N Kidney disease or malfunction
Y or N Liver disease
Y or N Low blood pressure
Y or N Mitral valve prolapse
Y or N Nervous problems
Y or N Pacemaker/Heart Surgery
Y or N Psychiatric care
Y or N Rapid weight gain or loss
Y or N Radiation treatment
Y or N Respiratory disease
Y or N Rheumatic fever or Heart Disease
Y or N Scarlet fever
Y or N Shingles
Y or N Shortness of breath
Y or N Skin rash
Y or N Spina Bifida
Y or N Stroke
Y or N Surgical implant
Y or N Swelling of feet/ankles
Y or N Thyroid disease or malfunction
Y or N Tobacco habit
Y or N Tuberculosis
Y or N Ulcer/Colitis
Y or N Venereal disease
Y or N Material Allergies (latex,wool,metal,chemicals)

Y or N DO YOU CURRENTLY REQUIRE ANTIBIOTICS BEFORE DENTAL TREATMENT

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING:

Y or N Aspirin
Y or N Codeine
Y or N Erythromycin
Y or N Dental Anesthetics
Y or N Latex
Y or N Jewelry/Metals
Y or N Penicillin
Y or N Tetracycline
Y or N Sulfa

List Medications, vitamins, herbs or supplements you are currently taking, and any other drugs/materials you may be allergic to:

_____

_____

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. 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 authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature _____ Date _____

Payment is due in full at time of treatment unless prior arrangements have been approved.