

WELCOME TO THE OFFICES OF MARGARET A. PIPPIN, DDS

GENERAL PRACTICE INFORMATION

Patient Information

Name _____ Preferred Name _____
Gender: ___M___F Marital Status ___S___M___O Date of Birth _____
Social Security # _____ Driver's License: _____ State _____ Number _____
Home Address _____ City _____ State _____ Zip Code _____
Billing Address (if different) _____ City _____ State _____ Zip Code _____
Home Phone # _____ Work Phone # _____ Cell Phone # _____
Email Address _____ Communication preference: ___email___text___phone
Employer _____ Occupation _____

Spouse/Parent Information

Name _____ Gender ___M___F Date of Birth _____
Social Security # _____ Employer _____ Work Phone _____

Dental Insurance Information (if applicable)

Dental Insurance Company _____ Insurance Phone # _____
Subscriber Name _____ Subscriber ID # _____
Subscriber Address _____ Subscriber DOB _____
Group Name _____ Group # _____

How will you paying your deductible, copayment and/or non-covered benefit today (if applicable)?

Choose one: ___Cash___ Check ___ Visa ___ MC ___ Amer. Exp ___ Discover

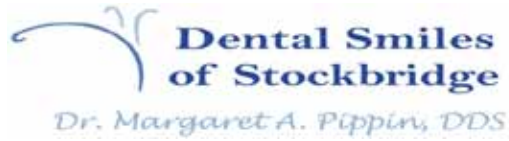
Emergency Contact Information

Name _____ Phone Number _____ Relation _____

Referral Information How did you hear about our office? _____

Release: I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care including the possible use of diagnostic x-rays, local anesthetic and fluoride. I authorize release of any information concerning my health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize release of any information concerning my health care, advice and treatment to another dentist or healthcare professional. I authorize payment of insurance benefits directly to the dentist otherwise payable to me. I understand my dental insurance carrier or payer of my dental benefits may pay less than the actual bill for services. **I understand I am financially responsible for payment in full of all services.** If balance is not paid in full within 30 days of the monthly billing date, a service charge will be added at a periodic rate of 1.5% per month which is an annual percentage rate of 18%. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part, by my dental care payer. I attest to the accuracy of the information on this page.

Patient or Guardian Signature _____ Date _____



PATIENT DENTAL HISTORY

How often do you normally visit the dentist? ___ Twice per year ___ Only when I have a problem ___ Other

Have you ever had any of the following?

- | | | | |
|-------------------------------------|-----|-----------------------------|-----|
| Periodontal Treatments | ___ | Root Canal Treatment | ___ |
| Oral Surgery or Extractions | ___ | Serious Injury to Mouth | ___ |
| Crowns or Bridges | ___ | Extensive Dental Procedures | ___ |
| Dental Implants | ___ | Dentures or Braces | ___ |
| Gum Disease | ___ | Partial Dentures | ___ |
| Excessive Bleeding After Extraction | ___ | Teeth Whitening | ___ |

Please indicate if you CURRENTLY have any of the following:

- | | | | |
|----------------------------------|-----|--|-----|
| Loose Teeth | ___ | Broken Fillings | ___ |
| Dry Mouth | ___ | Clicking or Popping When Opening Mouth | ___ |
| Chew on One Side of Mouth | ___ | Fingernail Biting | ___ |
| Grinding or Clenching Your Teeth | ___ | Jaw Pain or Tiredness | ___ |
| Pain During Chewing | ___ | Mouth Breathing | ___ |
| Does your jaw ever get "stuck" | ___ | Headaches or neck pains | ___ |
| Uncomfortable bite | ___ | Pain around Your Ear | ___ |
| Bleeding Gums | ___ | Swollen or Tender Gums | ___ |
| Broken or Worn Teeth | ___ | Tooth Ache | ___ |
| Bad Breath | ___ | Mouth Sores or Growths | ___ |
| Floss that Shreds | ___ | Rough Restorations | ___ |

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I hereby certify that the foregoing information is accurate and complete and that I will notify the office of any changes in a timely manner. I will not hold my dentist, or any other member of the office, responsible for any errors or omissions that I may have made in completion of this form. Should further information be needed, you have my permission to ask the respective health care provider or agency, which may release such information to you. I will notify the doctor of changes in my health and medication.

I authorize the use of my radiographs (x-rays) and/or photographs for educational & promotional use in seminars, publications and the dental office website. Yes ___ No ___

Patient or Guardian Signature

Date

Dentist's Signature

Date

HEALTH HISTORY

Name _____ Date _____

Date of last health exam: _____ Reason for exam: _____

Have you been hospitalized in the last 5 years? (Please circle) No Yes If yes, reason: _____

Are currently receiving care? Yes No If Yes, nature of care: _____

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. _____ 2. _____ 3. _____

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your responses. Our team may ask additional questions concerning your health.

<i>Anemia or Blood Disorder</i>	No Yes	<i>Hepatitis, Any Form</i>	No Yes
<i>Arthritis, Rheumatism or other inflammatory disease</i>	No Yes	<i>Joint Replacement - When Placed?</i>	No Yes
<i>Asthma</i>	No Yes	<i>Kidney Disease</i>	No Yes
<i>Abnormal bleeding from a cut</i>	No Yes	<i>Liver Disease</i>	No Yes
<i>Cancer or Tumor</i>	No Yes	<i>Sore/Enlarged Lymph Nodes</i>	No Yes
<i>Diabetes</i>	No Yes	<i>Psychosis</i>	No Yes
<i>Emphysema or other Respiratory/Lung Illnesses</i>	No Yes	<i>Previous Biopsies</i>	No Yes
<i>Epilepsy</i>	No Yes	<i>Radiation or Chemotherapy</i>	No Yes
<i>Fainting or Dizzy Spells</i>	No Yes	<i>Rheumatic Fever</i>	No Yes
<i>Glaucoma</i>	No Yes	<i>Slow-Healing Mouth Sores</i>	No Yes
<i>Abnormal Heart or Previous Bacterial Endocarditis</i>	No Yes	<i>Unintentional Weight Loss/Gain</i>	No Yes
<i>Heart Valve (artificial) or Heart Transplant</i>	No Yes	<i>H.I.V. Infection/AIDS or ARC</i>	No Yes
<i>Congenital Heart Disease</i>	No Yes	<i>Venereal Disease</i>	No Yes
<i>Heart Disease, Heart Attack, Heart Surgery</i>	No Yes	<i>Other Conditions</i>	No Yes
<i>Heart Stent When placed? _____</i>	No Yes	<i>Recurrent Illnesses</i>	No Yes

Are you taking any of these medications?

<i>Pre-medication before dental treatment</i>	No Yes	<i>Tagamet (cimetidine) or Prilosec (omeprazole)</i>	No Yes
<i>Dilantin or Tegretol</i>	No Yes	<i>Cardizem (diltiazem) or Calan, Isopin (verapamil)</i>	No Yes
<i>Barbituates (any)</i>	No Yes	<i>Diflucan (fluconazole) or Sporonox (itraconazole)</i>	No Yes
<i>St. John's Wort or Kava-Kava</i>	No Yes	<i>Serzone (nefazodone)</i>	No Yes
<i>Have you been treated with Bisphosphonate drugs (Fosamax, Aredia, Zometa, Actone, Boniva?)</i>			No Yes

If so, when did the treatment begin? _____ When did the treatment end? _____

Have you ever taken any prescription drugs such as fen-phen for weight loss? No Yes

Do you consume grapefruit juice, grapefruits or grapefruit extract? No Yes

Please list any medications you are currently taking and dosages:

Please list any dietary or herbal supplements you are taking:

Women: Are you pregnant No Yes

If no, are you planning a pregnancy in the near future? No Yes

Are you a nursing mother? No Yes

Are you taking birth control pills? No Yes

Abnormal Blood Pressure

No Yes

Have you ever received a diagnosis of "high blood pressure"?

No Yes

What is your normal blood pressure?

Are you allergic or have you had a reaction to:

a. Local anesthetics

No Yes

b. Penicillin or other antibiotics

No Yes

c. Aspirin, Ibuprofen or Tylenol

No Yes

d. Codeine, Valium or other sedatives

No Yes

e. Latex or Metals

No Yes

f. Other (please specify) _____

No Yes

Tobacco, Alcohol, Drugs

Do you use Tobacco? If yes, Circle type: smoke chew How much per day? For how long?

No Yes

Do you want to quit using tobacco?

No Yes

Do you consume alcohol? If yes, approximately how many alcoholic beverages per week

No Yes

Do you use any mood altering drugs other than those previously listed?

No Yes

Weight and Diet Considerations:

Weight _____ Meals per day _____ Dietary Restrictions _____ Food Allergies _____

DOCTORS USE ONLY

Comments on patient interview concerning medical history _____

Significant finding from questionnaire or oral interview: _____

Dental Management considerations: _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

Patient (Print Name)

Patient Signature

Date

Doctor (Print Name)

Doctor Signature

Date