Welcome to Feild Family Dentistry

We are pleased to welcome you to our practice. 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. Please return this form to our office at your appointment or by email addressed to office@feildfamilydentistry.com

Patient Information

Name_____ Soc. Sec. #_____
Last Name *First Name* *Initial*

Address _____
City_____ State_____Zip_____Home Phone _____
Cell Phone _____ Email _____
Sex ☐M ☐F Age _____ Birthdate _____ ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced
Patient Employed by _____ Occupation _____
Business Address _____ Business Phone_____
Business Email _____
Whom may we thank for referring you? _____
Notify in case of emergency _____ Home Phone _____
Cell Phone _____ Business Phone _____
Email _____

Primary Insurance

Person Responsible for Account_____
Last Name *First Name* *Initial*

Relation to Patient_____ Birthdate_____ Soc. sec. #_____
Address *(if not different from patient)* _____ Home Phone _____
City_____ State_____ Zip_____
Cell Phone _____ Email _____
Patient Responsible Employed by _____ Occupation _____
Business Address _____ Business Phone_____
Business Email _____
Insurance Company _____ Phone _____
Insurance Email _____
Contract # _____ Group #_____ Subscriber # _____
Name of other dependents under this plan _____

Additional Insurance

Is patient covered by additional insurance? ☐Yes ☐No
Subscriber Name _____ Relation to Patient _____ Birthdate _____
City_____ State_____Zip_____Home Phone _____
Address *(if not different from patient)* _____ Soc. Sec. # _____
Cell Phone _____ Email _____
Subscriber Employed by _____ Business Phone _____
Business Email _____
Insurance Company _____ Phone _____
Insurance Email _____
Contract # _____ Group #_____ Subscriber # _____
Name of other dependents under this plan _____

Please complete both pages.

Dental History

What would you like us to do today?_____ Are you in dental discomfort today?_____

Former Dentist _____ Address_____

Dentist's Email _____ Phone _____

Date of last dental care _____ Date of last x-rays _____

Check (√) yes or no if you have had problems with any of the following:

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

How often do you brush? _____ 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? ☐Y ☐N

Other information about your dental health or previous treatment _____

Medical History

Physician's name _____ Phone _____

Date of last visit _____ Have you had any serious illnesses or operations? ☐Y ☐N

If yes, describe _____

Are you currently under physician care? ☐Y ☐N If yes, describe _____

Have you ever had a blood transfusion? ☐Y ☐N If yes, give approximate dates_____

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

Have you ever used a bisphosphate medication? Brand names include Fosamax, Actonel, Atelvia, Didronel and Boniva. ☐Y ☐N

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

Check (√) yes or no whether you have had any of the following:

☐Y ☐N AIDS/HIV Positive	☐Y ☐N Cough, persistent	☐Y ☐N Jaw pain	☐Y ☐N Shingles
☐Y ☐N Anaphylaxis	☐Y ☐N Cough up blood	☐Y ☐N Kidney disease or malfunction	☐Y ☐N Shortness of breath
☐Y ☐N Anemia	☐Y ☐N Diabetes		☐Y ☐N Skin rash
☐Y ☐N Arthritis, Rheumatism	☐Y ☐N Epilepsy	☐Y ☐N Liver disease	☐Y ☐N Spina Bifida
☐Y ☐N Artificial hear valves	☐Y ☐N Fainting	☐Y ☐N Material allergies (latex, wool, metal, chemicals)	☐Y ☐N Stroke
☐Y ☐N Artificial joints	☐Y ☐N Food allergies		☐Y ☐N Surgical implant
☐Y ☐N Asthma	☐Y ☐N Glaucoma		☐Y ☐N Swelling of feet or ankles
☐Y ☐N Atopic (allergy prone)	☐Y ☐N Headaches	☐Y ☐N Mitral valve prolapse	
☐Y ☐N Back problems	☐Y ☐N Heart murmur	☐Y ☐N Nervous problems	☐Y ☐N Thyroid disease or malfunction
☐Y ☐N Blood disease	☐Y ☐N Heart problems	☐Y ☐N Pacemaker/ Heart surgery	☐Y ☐N Tobacco habit
☐Y ☐N Cancer	Describe _____	☐Y ☐N Psychiatric care	☐Y ☐N Tonsillitis
☐Y ☐N Chemical dependency	☐Y ☐N Hemophilia/ Abnormal bleeding	☐Y ☐N Rapid weight gain or loss	☐Y ☐N Tuberculosis
☐Y ☐N Chemotherapy		☐Y ☐N Radiation treatment	☐Y ☐N Ulcer/Colitis
☐Y ☐N Circulatory problems	☐Y ☐N Herpes	☐Y ☐N Respiratory disease	☐Y ☐N Venereal disea
☐Y ☐N Cortisone treatments	☐Y ☐N Hepatitis	☐Y ☐N Rheumatic/Scarlet fever	
	☐Y ☐N High blood pressure		

Is patient currently taking any medications? If yes, list all:

_____

_____

Does patient have drug allergies? If yes, list all:

_____

_____

Authorization

I have reviewed the information on this questionaire, 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. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this from to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment benefits. I understand that I am financially responsible for all changes whether or not paid by insurance.

Signature _____ Date _____

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