Family Dentistry On
MONTFORD
STEVEN D. ROBERTSON, DMD

PATIENT INFORMATION

How did you hear about our office? ____
Last Name: ______________________ First Name: _________________________ MI: ___________
Preferred Name: ___________________ DOB: _________________ Age: ____________ M ☐ F ☐
Social Security Number: ____-____-______
Address: _____________________________________ City/State________________ Zip: _________
Cell Phone: (____)___________ Home Phone: (____)___________ Work Phone: (____)___________
Email Address: _________________________________
Marital Status: Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐
Spouse's Last Name: ____________________ First Name: ____________________ MI: __________
Cell Phone: (____)___________ Home Phone: (____)___________ Work Phone: (____)___________
Emergency Contact: ____
Phone Number: (____)___________

Primary Insurance Information

Please provide us with your insurance card to copy for your file. We are happy to assist you in filing your insurance; however, you are responsible for your account balance.

Subscriber: __________________ Relationship to Insured: Self ☐ Spouse ☐ Child ☐ Other ☐
Subscriber's SSN: ____-____-____ Subscriber's DOB: _____/______/_____
Subscriber's Address:____
Employment Status: Full Time ☐ Part Time ☐ Retired ☐
Employer: ____________________________
Employer's Address:____
Insurance Company:____
Subscriber ID: ____________ Group Number: __________ Insurance Co. Phone: (____)___________

Secondary Insurance Information

Subscriber: __________________ Relationship to Insured: Self ☐ Spouse ☐ Child ☐ Other ☐
Subscriber's SSN: ____-____-____ Subscriber's DOB: _____/______/_____
Subscriber's Address:____
Employment Status: Full Time ☐ Part Time ☐ Retired ☐
Employer: ______________________
Employer's Address:____
Insurance Company:____
Subscriber ID: ____________ Group Number: __________ Insurance Co. Phone: (____)___________

Responsible Party

(if someone different than the patient)

Name: ____
Address: ____
Cell Phone: (____)____-______ Home Phone: (____)____-______ Work Phone: (____)____-______
DOB: _____/______/_____ Age:______ Social Security Number: ____-____-____
Policy Holder for Patient ☐ Primary Insurance Holder ☐ Secondary Insurance Holder ☐
Relationship to Patient:____

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DENTAL HISTORY

Today's Date: ___________________
Who was your former dentist? Name: ____
City: _______________________ State: ________ Zip: __________ Phone: (____)_______________
When was your last dental visit? ____/_____/______ Type of Appointment: ____________________
How would you describe your present dental health? Great ☐ Good ☐ Fair ☐ Poor ☐
What is the reason for today's appointment? ____

	Y	N		Y	N
Are you currently experiencing dental pain or discomfort?	☐	☐	Do your gums bleed when you are brushing or flossing?	☐	☐
Is your mouth dry?	☐	☐	Are your teeth sensitive?	☐	☐
Do you clench or grind your teeth?	☐	☐	Do you have any popping, clicking or pain in your jaw?	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	Have you ever had periodontal (gum) treatment?	☐	☐
Have you ever had orthodontic treatment (braces)?	☐	☐	Have you ever had problems with previous dental treatment?	☐	☐
Are you satisfied with your tooth color?	☐	☐	Do you hide your teeth when you smile?	☐	☐

Please explain any **YES** answers:____
____
How do you feel about your smile? ____
Is there something you would like to change about your smile? ____________________________________

MEDICAL HISTORY

Have you been hospitalized, had a serious illness or operation in the past 2 years? Yes ☐ No ☐
If **YES**, please explain: ____
Primary Care Physician's Name: _________________________ Date of Last Exam: _______________

Are you allergic or have you had a reaction to any of the following?

Penicillin	☐	Aspirin	☐
Clindamycin	☐	Ibuprofen/NSAIDs	☐
Other Antibiotics	☐	Food	☐
Sulfa Drugs	☐	Local Anesthetic	☐
Codeine or Other Narcotics	☐	Other	☐

If **YES**, please give additional details:____
____
____

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MEDICAL HISTORY

Please list any prescription or over the counter medications, vitamins or natural supplements that you are currently taking or have been prescribed:

______________________________________ ______________________________________
______________________________________ ______________________________________
______________________________________ ______________________________________
______________________________________ ______________________________________

Check any of the following which you have had or have at present:

- Acid Reflux/Persistent Heartburn ☐
- Alcoholism ☐
- AIDS or HIV Infection ☐
- Arthritis ☐
- Autoimmune Disease:
  - Rheumatoid Arthritis ☐
  - Lupus ☐
  - Sjogren's Syndrome ☐
  - Other _________________
- Blood Disorder:
  - Anemia ☐
  - Bruise Easily ☐
  - Clot Easily ☐
  - Hemophilia ☐
  - Other _________________
- Blood Transfusion ☐
- Breathing Problems/Lung Disease
  - Asthma ☐
  - Bronchitis ☐
  - COPD ☐
  - Cough that Produces Blood ☐
  - Emphysema ☐
  - Persistent Cough ☐
  - Tuberculosis ☐
  - Other _________________
- Cancer ☐
  - Type _________________
  - Chemotherapy ☐
  - Radiation ☐

- Cardiovascular Disease
  - Angina ☐
  - Atrial Fibrillation ☐
  - Chest Pain Upon Exertion ☐
  - Congestive Heart Failure ☐
  - Damaged Heart Valves ☐
  - Heart Attack ☐
  - Heart Murmur ☐
  - High Cholesterol ☐
  - High Blood Pressure ☐
  - Low Blood Pressure ☐
  - Mitral Valve Prolapse ☐
  - Other Congenital Heart Defects ☐
  - Pacemaker ☐
  - Prosthetic (Artificial) Heart Valve ☐
  - Rheumatic Heart Disease ☐
- Chronic Pain ☐
- Diabetes
  - Type I ☐
  - Type II ☐
- Drug Addiction ☐
- Eating Disorder ☐
- Epilepsy ☐
- Fainting Spells ☐
- Gastrointestinal Disease ☐
- Glaucoma ☐
- Liver Disease
  - Hepatitis A ☐
  - Hepatitis B ☐
  - Hepatitis C ☐
  - Cirrhosis ☐
  - Other ________________

- Hypoglycemia ☐
- Kidney Disease ☐
  - Renal Dialysis ☐
  - Other ________________
- Mental Health Disorder
  - Depression ☐
  - Anxiety ☐
  - Bipolar Disorder ☐
  - Other ________________
- Migraines/Headaches ☐
- Osteoporosis ☐
- Recurrent Infections ☐
- Rheumatic Fever ☐
- STD/STI ☐
- Shingles ☐
- Sinus Trouble ☐
- Sleep Disorder
  - OSA ☐
  - CSA ☐
- Stroke ☐
- Thyroid Disease ☐
- Tobacco Use ☐
  - Interested in quitting? ☐
- Total Joint Replacement ☐
  - Joint ________________
  - Date ________________
- Ulcer ☐

WOMEN ONLY

- Oral Contraceptives ☐
- Nursing ☐
- Pregnant ☐
- Due Date: ________________

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MEDICAL HISTORY

Have you been treated with or are you scheduled to be treated with:

Fosamax/alendronate	☐	Aremedia/I.V. bisphosphonate	☐
Actonel/risedronate	☐	Zometa/I.V. bisphosphonate	☐
Reclast/zoledronic acid	☐	Prolia/denosumab	☐

Have you taken cortisone or prednisone in the last month? Yes ☐ No ☐
Have you ever taken antibiotics prior to dental treatment? Yes ☐ No ☐

Do you have any other diseases, conditions or problems that you feel we should know about?
If so, please explain:

____

____

____

To the best of my knowledge, the questions on this form have been answered accurately. I understand the importance of providing accurate health information to my dentist as the dentist and staff will rely on this information for treating me. I realize that incorrect or incomplete health information can be dangerous to my health.

____ _____________________

Patient/Guardian Signature Date