Bold Smiles Dental Office
Patient Health Information

Name (Last) _________________________ (First) ______________ M.I.___ Nickname ______________________

Address ____ City, State & Zip ________________________________

Marital Status: S M O Male__ Female__ SS# _______________ Patient's Birthday_______________

Home Phone# _____________________ Cell Phone# __________________ Work Phone#_____________________

Your Place of Employment______________________ Occupation____________ E-mail_________________________

Spouse's Name____________________________________ Spouse's Employer _____________________________

Insurance Subscriber Name___________________ **Date of Birth**_________ **Subscriber SS#** __________________

Insured person's place of employment___________________________ Work Phone#________________________

Your Relationship to Insurance Subscriber: Self / Spouse / Child / Other

Dental Insurance Company and Phone #____________________________________ **Group #** __________________

Person responsible for this account? ___________________________________ Phone# _________________________

In Case of Emergency Contact Person: ________________________________ Phone#__________________________

Has any member of your family ever been treated in our office? ____

To whom may our office thank for referring you to Dr. Jeremy Bold?____

Insurance Disclaimer

I understand that my insurance is an agreement between me and my insurance company and that I am responsible for my balance regardless of my insurance. I assign dental benefit payments to be paid directly to Dr. Bold from my insurance company.

Patient's (Parent's) Signature____________________________________ Date_____________________

Initial Treatment Consent

I give permission for my dentist and his/her clinical team to take any necessary x-rays, photos, or study models to enable complete diagnosis and treatment.

Patient's (Parent's) Signature___________________________________ Date_____________________

Dental History

	Please Circle	
Do you have a specific dental problem? Describe________________________________	Yes	No
Do you have routine dental exams? Last Visit___________________________________	Yes	No
Do you think you have active decay or gum disease?_____________________________	Yes	No
Do you brush and floss on a routine basis?_____________________________________	Yes	No
Do your gums ever bleed?____	Yes	No
Is there any part of your smile that you want to improve? ________________________	Yes	No
Would you like the color of your teeth to be whiter?______________________________	Yes	No
Are there old fillings or dental work that you don't like?__________________________	Yes	No
Have you ever been treated for gum (periodontal) disease?_________________________	Yes	No
Do you ever have trouble with Halitosis (bad breath)?_____________________________	Yes	No
Do you clench or grind your teeth during the day or night?_________________________	Yes	No
Have you ever had an unpleasant dental experience?_______________________________	Yes	No

Medical History

Have you ever had any of the following? (check boxes that apply) Today's Date________________

	Yes	No		Yes	No		Yes	No
Heart Problems ♥			Asthma			Stroke		
High Blood Pressure			Epilepsy			Ulcer		
Low Blood Pressure			Headaches			Venereal Disease		
Circulatory Problems			Hepatitis or Jaundice			Hemophilia		
Heart Murmurs ♥			Cancer			Nervous Problems		
Radiation Treatment			Respiratory Problems			Excessive Bleeding		
Artificial heart valve ♥			Psychiatric Care			Tuberculosis		
Artificial Joint ♥			Blood Disease			Alcohol Addiction		
Anemia			Arthritis			Drug Addiction		
Phen/Fen ♥			Thyroid Disorder			Diabetes		
Mitral Valve Prolapse ♥			Swollen Neck Glands			Dizziness or Fainting		
Heart Surgery ♥			Recent Weight Loss			Kidney Problems		
Rheumatic Fever ♥			Sinus Problems			Cortisone Medicine		
Heart Pacemaker ♥			A.I.D.S.			HIV Positive		

Physician's Name____ Phone #____________________ *Please Circle*

Have you ever been hospitalized or had a major operation? Discuss____________________________________ Yes No

Have you ever had a serious injury to your head or neck? Discuss______________________________________ Yes No

Have you ever responded adversely to medical or dental treatment?____________________________________ Yes No

Do you smoke or chew tobacco? How much?____ Yes No

Do you have trouble breathing or snoring while sleeping?____ Yes No

Please list any medications, pills, or drugs that you are taking ____

____

Please check any medications or substances that you may be allergic to below:

Aspirin Penicillin Codeine Acrylic Metal Latex Other ___________________________

Have you had any significant illness not checked above? Discuss____

WOMEN (Please Check): Pregnant Nursing Taking Oral Contraceptives Menopause

I have read my MEDICAL HISTORY and confirm that it adequately states past and present conditions.

<u>Cancellation Policy</u>: We kindly request 48 hours notice if canceling or changing an appointment. We reserve the right to charge $75 per hour if adequate notice is not given. Thank you.

Patient's or (Parent) Signature_________________________________ Reviewed by Dr.____________________________

Medical Updates

Date	Changes in Medical History		Patient Signature	Reviewed By
________	____	None	___________________________	_________________.
________	____	None	___________________________	_________________.
________	____	None	___________________________	_________________.
________	____	None	___________________________	_________________.