Creekview Dental

Welcome! The benefits of good oral health are endless, and we want to help you obtain and maintain a happy, healthy smile. Please fill out this form as completely as you can. The more we know about you, the better we can take care of you. Thank you.

Patient Registration

Name I prefer to be called

☐ M/☐ F ☐ Single/☐ Married/☐ Divorced/☐ Widowed/☐ Separated

Home Address

City State Zip

Birth Date SS#

Home Phone Work Phone Cell Phone

Email Address

Contact/reminder preference:
☐ Home phone/ ☐ Work phone/ ☐ Cell phone/ ☐ Email

Occupation

Employer Length of Employment

If you are a student, where do you go to school?

If you are under 18, name(s) of your parents

Who may we thank for referring you?

Spouse Information

Name Birth Date

Occupation Employer

In the event of an emergency, we should contact:

Name Relationship

Phone numbers

Person Responsible for Account Same as patient____

Name Relationship

Billing Address

City State Zip

Phone 1 Phone 2

Dental Insurance—Primary

Insurance Company Name Insurance Company Phone

Insured's Employer Group Number

Insured's Name Relationship

Insured's Birth Date Insured's SS#

Dental Insurance—Secondary

Insurance Company Name Insurance Company Phone

Insured's Employer Group Number

Insured's Name Relationship

Insured's Birth Date Insured's SS#

Dental History

Why have you come to the dentist today? _____

Are you having pain or discomfort? Y☐ N☐

Have you experienced problems with previous dental work? Y☐ N☐

Please explain:_____

Are you apprehensive about going to the dentist? Y☐ N☐

My current dental health is: ☐ Good/☐ Fair/☐ Poor

Do your gums ever bleed? Y☐ N☐

Have you ever received treatment for periodontal disease? Y☐ N☐

Are any of your teeth loose? Y☐ N☐

Have you lost any adult teeth? Y☐ N☐

Why? _____

Are any of your teeth especially sensitive to temperature? Y☐ N☐

Are any of your teeth sensitive to chewing? Y☐ N☐

Are any of your teeth sensitive to sweet things? Y☐ N☐

Do you clench your teeth? Grind your teeth? Y☐ N☐

Are you happy with the way your smile looks? Y☐ N☐

If not, what would you change about it? _____

Previous dentist _____

Date of last dental visit _____

What was done then? _____

Medical History

Are you currently under a physician's active care? Y☐ N☐

If yes, for what? _____

_____

Physician Phone

Have you had a medical condition or accident requiring hospitalization in the past 3 years? Y☐ N☐

Please explain: _____

Do you smoke or use tobacco in any form? Y☐ N☐

If yes, how much and for how long? _____

Review of Symptoms

	Have Now	Had in Past	Never Had		Have Now	Had in Past	Never Had		Have Now	Had in Past	Never Had
AIDS/HIV Positive	☐	☐	☐	Excessive Bleeding	☐	☐	☐	Mitral Valve Prolapse	☐	☐	☐
Alzheimer's Disease	☐	☐	☐	Excessive Thirst	☐	☐	☐	Pain in Jaw Joints	☐	☐	☐
Anemia	☐	☐	☐	Fainting Spells/Dizziness	☐	☐	☐	Parathyroid Disease	☐	☐	☐
Angina	☐	☐	☐	Frequent Cough	☐	☐	☐	Psychiatric Care	☐	☐	☐
Arthritis/Gout	☐	☐	☐	Frequent Headaches	☐	☐	☐	Radiation Treatments	☐	☐	☐
Artificial Heart Valve	☐	☐	☐	Glaucoma	☐	☐	☐	Recent Weight Loss	☐	☐	☐
Artificial Joint	☐	☐	☐	Hay Fever	☐	☐	☐	Renal Dialysis	☐	☐	☐
Asthma	☐	☐	☐	Heart Attack/Failure	☐	☐	☐	Rheumatic Fever	☐	☐	☐
Blood Disease	☐	☐	☐	Heart Murmur	☐	☐	☐	Rheumatism	☐	☐	☐
Blood Transfusion	☐	☐	☐	Heart Pacemaker	☐	☐	☐	Scarlet Fever	☐	☐	☐
Breathing Problem	☐	☐	☐	Heart Trouble/Disease	☐	☐	☐	Shingles	☐	☐	☐
Bruise Easily	☐	☐	☐	Hemophilia	☐	☐	☐	Sickle Cell Disease	☐	☐	☐
Cancer	☐	☐	☐	Hepatitis B or C	☐	☐	☐	Sinus Trouble	☐	☐	☐
Chemotherapy	☐	☐	☐	Herpes	☐	☐	☐	Stomach/Intestinal Disease	☐	☐	☐
Chest pains	☐	☐	☐	High Blood Pressure	☐	☐	☐	Stroke	☐	☐	☐
Cold Sores/Fever Blisters	☐	☐	☐	Hives or Rash	☐	☐	☐	Swelling of Limbs	☐	☐	☐
Congenital Heart Disorder	☐	☐	☐	Hypoglycemia	☐	☐	☐	Thyroid Disease	☐	☐	☐
Convulsions	☐	☐	☐	Irregular Heartbeat	☐	☐	☐	Tuberculosis	☐	☐	☐
Cortisone Medicine	☐	☐	☐	Kidney Problems	☐	☐	☐	Tumors or Growths	☐	☐	☐
Diabetes	☐	☐	☐	Leukemia	☐	☐	☐	Ulcers	☐	☐	☐
Drug Addiction	☐	☐	☐	Liver Disease	☐	☐	☐	Venereal Disease	☐	☐	☐
Emphysema	☐	☐	☐	Low Blood Pressure	☐	☐	☐	Yellow Jaundice	☐	☐	☐
Epilepsy or Seizures	☐	☐	☐	Lung Disease	☐	☐	☐				

Current Medications

Are you currently taking **ANY** medications or drugs (prescription, OTC or otherwise)? Y☐ N☐

If so, please list medications and purpose.

Do you require antibiotic premedication prior to dental treatment for things such as a heart valve or a joint replacement? Y☐ N☐

Allergies

Are you allergic to or had an unfavorable reaction to any of the following?

- ☐ Penicillin
- ☐ Other Antibiotics
- ☐ Codeine
- ☐ Aspirin
- ☐ Ibuprofen/Advil/Motrin
- ☐ Novocaine/local anesthetics
- ☐ Other drugs or medications
- ☐ Latex
- ☐ Metals
- ☐ Acrylic

Please list any other allergies you may have _____

_____

For Women

Are you pregnant now? Y☐ N☐

Are you nursing? Y☐ N☐

I understand that the information I have given today is correct to the best of my knowledge. I 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.

_____ _____

Signature Date

I understand that all responsibility for payment for dental services provided in this office for myself and/or my dependents is mine, due and payable at the time services are rendered unless other arrangement have been made. In the event payments are not received by the agreed upon dates, I understand that a 1½% finance charge (18% APR) may be added to my account and that expenses incurred to collect a delinquent payment will be added to the account due.

_____ _____

Signature Date