Cullimore Family Dentistry

Patient Information

Date: _____ **(Please Circle One)** **Male / Female**

Patients Name: _____ _____
Last First MI Preferred Name

Family Status (please circle one): Married Single Child Other

Birth Date: _____ **Social Security #:** _____

Email: _____ **Are you able to receive text messages**? _____

Phone: ( ) _____ ( ) _____ ( ) _____ _____
Home Cell Work Ext

Address: _____ _____ _____ _____
City State Zip Code

Occupation: _____ **Employer**: _____

Whom may we thank for referring you to our office? _____

If not a patient then please list source of referral: _____

Contact in case of an emergency? _____ ( )_____
Name of Contact Phone #

Responsible Party

(If different from above)

Name: _____ ( ) _____
Last First MI Phone #

Address: _____ _____ _____ _____
City State Zip Code

Birth Date: _____ **Social Security #:** _____

Relationship to Patient? (spouse, guardian, etc.) _____

Primary Dental Insurance Information

Insured's Name: _____ _____
Last First MI Insured's Soc. Sec. #

Birth Date: _____ **ID #**: _____

Insurance Company: _____ **Group #**: _____

Insurance Co. Address: _____

Insurance Co. Phone #: ( ) _____

Insured's Employer: _____ **Employer Phone #**: ( ) _____

Patient Dental and Medical History

Name of Previous Dentist and Location: _____ **Date of Last Dental Visit**: _____
How many times a week do you floss? _____ **How many times a day do you brush?** _____
Would you like your teeth whiter? _____ **Do you like your smile?** _____

Please circle "Yes" or "No" to indicate if you have had any of the following:

Gums swollen or tender	Yes	No	Grinding your teeth	Yes	No
Lip or Cheek or Tongue biting	Yes	No	Sores/Growths in your mouth	Yes	No
Bad breath	Yes	No	Jaw Pain	Yes	No
Periodontal Treatment	Yes	No	Loose teeth or broken fillings	Yes	No
Bleeding gums	Yes	No	Sensitivity to sweets	Yes	No
Blisters on Lip or Mouth	Yes	No	Sensitivity to heat / cold	Yes	No
Clicking or popping jaw	Yes	No	Sensitivity when biting	Yes	No
Dry mouth	Yes	No	Burning sensation on tongue	Yes	No
Food collection between teeth	Yes	No	Trauma in mouth	Yes	No
Anxiety	Yes	No			

Physician's Name: _____ **Phone #**: ( ) _____ **Last Visit Date**: _____

Pharmacy Name: _____ **Phone #:** ( ) _____

***Women:** **Are you pregnant?**	**Yes**	**No**
Are you nursing?	**Yes**	**No**
Are you taking Birth Control Pills?	**Yes**	**No**

Please Circle if you are allergic to or had any reactions to:

Ampicillin	Aspirin/Ibuprofen	Augmentin
Latex	Codeine	Sulfa
Percocet	Morphine	Local Anesthetic
Penicillin	Tetracycline	ANY Metals

Please list any other allergies you may have: _____

Are you taking blood thinners? **Yes** **No** **Baby Aspirin?** **Yes** **No** **How often?** _____
Do you need to take antibiotics prior to dental appointments? **Yes** **No**
Have you used bisphosphonate medications such as Actonel, Fosamax or Zometa within the past 12 years? **Yes** **No**
Are you currently taking any prescription or non-prescription medications (If yes, please list): _____
_____

Please Circle "Yes" or "No" to indicate if you have had any of the following:

ADHD	Yes	No	Circulatory problems	Yes	No	Liver Disease	Yes	No
AIDS/HIV	Yes	No	Cortisone Treatments	Yes	No	Mitral Valve Prolapse	Yes	No
Allergies (seasonal)	Yes	No	Cough (persistent/bloody)	Yes	No	Nervous problems	Yes	No
Anemia	Yes	No	Diabetes	Yes	No	Pacemaker	Yes	No
Arthritis	Yes	No	Epilepsy	Yes	No	Psychiatric care	Yes	No
Artificial Heart Valves	Yes	No	Fainting or Dizziness	Yes	No	Radiation Treatments	Yes	No
Artificial Joints	Yes	No	Glaucoma	Yes	No	Respiratory problems	Yes	No
Asthma	Yes	No	Headaches	Yes	No	Scarlet Fever	Yes	No
Back Problems	Yes	No	Heart Murmur	Yes	No	Shortness of breath	Yes	No
Bleeding abnormally			Heart problems	Yes	No	Skin rash	Yes	No
with extractions of surgery	Yes	No	Hemophilia	Yes	No	Stroke	Yes	No
Blood disease	Yes	No	Hepatitis	Yes	No	Thyroid problems	Yes	No
Cancer	Yes	No	Herpes	Yes	No	Tobacco habit	Yes	No
Chemical dependency	Yes	No	High Blood Pressure	Yes	No	Tuberculosis	Yes	No
Chemotherapy	Yes	No	Kidney Disease	Yes	No	Ulcers	Yes	No

Describe any conditions not listed above: _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including diagnosis and records of my treatment or examination rendered to me (or my child) during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist any insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services and agree to be responsible for payment of all services rendered on my behalf or my dependents. In the event that I seek credit from the dental office, I consent to release a copy of my credit report to the dental office.

Signature of Patient: _____ Signature of Doctor: _____