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donharveydental.com

Don Harvey Dental
Comprehensive Family Dentistry

Welcome! We are pleased you have chosen our practice for your dental care. Our goal is to help you maintain your best overall health. We appreciate you completing this form in its entirety so we can provide you with comprehensive treatment. Your responses will be kept absolutely confidential. Please remember, we are here for you!

How did you hear about our practice? ______________________

Whom may we thank for referring you? ______________________

Special Needs - List any special concerns or requirements:

____

____

PATIENT INFORMATION

Patient Name ______________________
Last name

______________ ______ ______________
First name MI Prefer to be called

Email ______________________

Address ______________________

City ______________________

State ______________ Zip ______________

Sex ☐ Male ☐ Female Age ________

Birth Date ______________ (mm/dd/yyyy)

Marital Status ______________________

Patient Employer ______________________

Occupation ______________________

If Student, List School Name ______________

PHONE NUMBERS

Home ______________ Work ______________ Cell ______________

Best time to reach you? ______________________

How do you prefer we contact you? ☐ Phone ☐ Email

Preferred appointment times: ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Morning ☐ Afternoon ☐ Any Time

MEDICAL INSURANCE

Insurance Company ______________________

ID/Subscriber Number ______________________

Group Number ______________________

Phone Number ______________________

Is Patient covered by additional insurance? ☐ Y ☐ N

Subscriber's Name ______________________

DOB ______________ (mm/dd/yyyy)

Relationship to Patient ______________________

DENTAL INSURANCE

Insurance Company ______________________

ID/Subscriber Number ______________________

Group Number ______________________

Phone Number ______________________

Is Patient covered by additional insurance? ☐ Y ☐ N

Subscriber's Name ______________________

DOB ______________ (mm/dd/yyyy)

Relationship to Patient ______________________

HEALTH HISTORY

On a scale of 1-10 (unhealthy to healthiest), how do you rate your current health condition?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Please share anything about your current health condition that you would like to change:

___

How often do you exercise? ______________________ Do you eat a well balanced diet? ☐ Y ☐ N

On average, how many hours do you sleep each night? _____ hrs Upon awakening, do you feel rested? ☐ Y ☐ N

Do you use CPAP, BIPAP or similar device for a diagnosed sleep disorder? ☐ Y ☐ N

Physician's Name ______________________ When was your last physical exam? ______________________

Are you currently under a physician's care for existing health conditions? ☐ Y ☐ N

If yes, please explain ______________________

Have you had any serious illnesses or operations in the last 5 years? ☐ Y ☐ N

Describe ______________________

Indicate "yes" or "no" if you have had any of the following:

Condition	Y	N	Condition	Y	N	Condition	Y	N
Acid Reflux	☐	☐	Emphysema/COPD	☐	☐	Paralysis	☐	☐
AIDS/HIV	☐	☐	Epilepsy	☐	☐	Psychiatric Care	☐	☐
Anemia	☐	☐	Fainting or Dizziness	☐	☐	Radiation Treatment	☐	☐
Arthritis, Rheumatism	☐	☐	Glaucoma	☐	☐	Respiratory Disease	☐	☐
Artificial Heart Valves	☐	☐	Head or Neck Injuries	☐	☐	Rheumatic Fever	☐	☐
Artificial Joints	☐	☐	Headaches	☐	☐	Scarlet Fever	☐	☐
Asthma	☐	☐	Hearing Problems	☐	☐	Shortness of Breath	☐	☐
Back Problems	☐	☐	Heart Murmur	☐	☐	Sinus Trouble	☐	☐
Bleeding abnormally, with extractions or surgery	☐	☐	Heart Problems	☐	☐	Skin Rash	☐	☐
			Hepatitis	☐	☐	Special Diet	☐	☐
Blindness	☐	☐	Herpes/Fever Blisters	☐	☐	Stroke	☐	☐
Blood Disease	☐	☐	High Blood Pressure	☐	☐	Swollen Feet or Ankles	☐	☐
Cancer	☐	☐	Low Blood Pressure	☐	☐	Swollen Neck Glands	☐	☐
Chemical Dependency	☐	☐	Kidney Disease	☐	☐	Thyroid Problems	☐	☐
Chemotherapy	☐	☐	Liver Disease	☐	☐	Tobacco use	☐	☐
Circulatory Problems	☐	☐	Jaundice	☐	☐	Tuberculosis	☐	☐
Congenital Heart Lesions	☐	☐	Mitral Valve Prolapse	☐	☐	Tumor or growth	☐	☐
Cortisone Treatments	☐	☐	Nervous Problems	☐	☐	Stomach Ulcer	☐	☐
Cough, persistent or bloody	☐	☐	Osteoporosis	☐	☐	HPV	☐	☐
Diabetes	☐	☐	Pacemaker	☐	☐	Weight Loss, unexplained	☐	☐

ALLERGIES

- [ ] Aspirin
- [ ] Local Anesthetic
- [ ] No known
- [ ] Codeine
- [ ] Metals
- [ ] Other
- [ ] Iodine
- [ ] Penicillin
- [ ] Latex
- [ ] Sulfa

MEDICATIONS

List any prescription medications you are currently taking and the correlating diagnosis:

List any dietary supplements, vitamins, herbal or over-the-counter medicines you may be taking:

WOMEN

Are you Pregnant? [ ] Y [ ] N

Due Date ____________________ (mm/dd/yy)

Are you nursing? [ ] Y [ ] N

Are you taking birth control? [ ] Y [ ] N

Are you currently taking any Blood Thinners? [ ] Y [ ] N

Are you currently taking any Bisphosphonates? [ ] Y [ ] N

Are you currently taking any Calcium supplements? [ ] Y [ ] N

if "yes", how much? ____________________

Have you ever taken SSRI meds (antidepressants)? [ ] Y [ ] N

if "yes", how much? ____________________

Have you ever taken ADHD meds? [ ] Y [ ] N

if "yes", how much? ____________________

Pharmacy Name ____________________

Pharmacy Phone ____________________

DENTAL HISTORY

- [ ] Bridges
- [ ] Dental Implants
- [ ] Orthodontics
- [ ] Root Canals
- [ ] Cosmetics Elective
- [ ] Fillings
- [ ] Periodontal (Deep) Cleanings
- [ ] Other
- [ ] Crowns
- [ ] Oral Surgery/Extractions
- [ ] Periodontal (Gum) Surgery

____

Are any of the following an obstacle to your receiving dental care:

Fear of pain, surgery or infections? [ ] Y [ ] N

The cost of treatment? [ ] Y [ ] N

[ ] Other ____________________

Fear of past dental experiences? [ ] Y [ ] N

Time away from your job? [ ] Y [ ] N

When was your last dental cleaning ____________________

Former Dentist ____________________

City/State ____________________

Phone ____________________

Do you like your smile? [ ] Y [ ] N

Would you like a complementary Smile Analysis? [ ] Y [ ] N

Is there anything you would like to change about your smile? [ ] Y [ ] N

Please explain ____________________

Place an "X" to indicate if you have any of the following symptoms:

- [ ] Clicking or popping jaw
- [ ] Dental Implants
- [ ] Neck Tension/Pain
- [ ] Back Tension/Pain
- [ ] Jaw pain or tenderness
- [ ] TMJ Problems
- [ ] Shoulder Tension/Pain
- [ ] Pain around ear

If so, lower, middle, upper? ____________________

Please indicate if you are currently experiencing any of the following:

Bad breath	☐ Y	☐ N	Sores or growths in your mouth	☐ Y	☐ N	Broken fillings	☐ Y	☐ N
Bleeding gums	☐ Y	☐ N	Burning sensation on tongue	☐ Y	☐ N	Lip or cheek biting	☐ Y	☐ N
Gums swollen or tender	☐ Y	☐ N	Chew on one side of mouth	☐ Y	☐ N	Food collection between the teeth	☐ Y	☐ N
Blisters on lips or mouth	☐ Y	☐ N	Dry mouth	☐ Y	☐ N	Mouth breathing	☐ Y	☐ N
Mouth Ulcers	☐ Y	☐ N						

IN CASE OF EMERGENCY, CONTACT:

Name of Contact ____________________ Relationship of Patient ____________________

Home Phone ____________________ Work Phone ____________________

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage. As a courtesy, Dr. Donald Harvey will be filing my insurance claims. I authorize any and all insurance benefits to be assigned directly to Dr. Donald Harvey, otherwise payable to me, for services rendered. Therefore, I authorize Dr. Donald Harvey to disclose my health care information to my insurance company. I authorize the use of my signature on all insurance claim submissions for the purpose of pre-determining insurance benefits, obtaining benefits for services rendered and obtaining benefits for related services. I understand that I am financially responsible for the total balance of services rendered to me and/or my dependants whether they are covered by my insurance policy or not.

____
Please print name of Patient, Parent, Guardian or Personal Representative

____________________ ____________________
Date (mm/dd/yy) Relationship to Patient

"To the best of my knowledge, I have answered all of the above questions truthfully and accurately."

____
Signature of Patient, Parent, Guardian or Personal Representative

By typing your name, you agree that it represents your digital signature.

"I give consent for use of my photographs, radiographs, models and the like for educational purposes. My name will be held in strict confidentiality."

____
Signature of Patient, Parent, Guardian or Personal Representative

By typing your name, you agree that it represents your digital signature.

Print this form, fill out the fields, and bring to our office.