red maple dental
COMPREHENSIVE AND SEDATION DENTISTRY

PATIENT INFORMATION

LAST _____ FIRST _____ DATE OF BIRTH _____
mm/dd/yyyy

ADDRESS _____

PHONES: HOME _____ CELL _____ WORK _____

S.S.#_____ E-MAIL _____

OCCUPATION _____

EMPLOYER _____

EMPLOYER ADDRESS _____

SPOUSE/PARTNER NAME _____

EMERGENCY CONTACT _____ PHONE _____
(different than spouse/partner if able)

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?_____

DENTAL INSURANCE

INS COMPANY _____ PHONE _____

ADDRESS _____

INSURED'S NAME _____ DOB _____ RELATION _____
mm/dd/yyyy

ID/SS# _____ GROUP# _____

INSURED'S EMPLOYER _____

EMPLOYER'S ADDRESS _____

DENTAL INSURANCE AUTHORIZATION

I hereby authorize release of any information relating to dental treatment to my dental insurance company for processing of dental claims.

SIGNATURE (if applicable)_____ **DATE** _____
mm/dd/yyyy

LAST NAME _____ FIRST NAME _____

DENTAL HISTORY

What is the reason for your dental visit today?

When was your last visit to the dentist? _____

Who is your previous or referring dentist? _____

Would you like us to request your dental records be transferred? ◯Yes ◯No

How frequently do you brush your teeth?

◯ 3(+) a day ◯ Twice a day ◯ Once a day ◯ Weekly ◯ Seldom

How frequently do you floss your teeth?

◯ 1(+) a day ◯ 2-6 times per week ◯ A few times a month ◯ Seldom ◯ Never

Place a **mark beside** any of the following statements that reflect **your current condition**:

☐	I am experiencing dental pain	☐	I feel anxious when I think about dental treatment
☐	I have a lump or sore	☐	I would like Oral/IV Sedation for future procedures
☐	I have difficulty swallowing	☐	I have had a complication following dental treatment
☐	I have a loose tooth	☐	I have a reaction to local anesthetics or epinephrine
☐	My gums bleed when I brush or floss	☐	I have a dental implant, denture or partial
☐	I have a bad taste or odor in my mouth	☐	I have had orthodontic treatment
☐	My teeth are sensitive to hot, cold, or sweets	☐	I have had treatment from a periodontist
☐	Food gets caught between my teeth	☐	I breathe through my mouth at night
☐	I have frequent or tension headaches	☐	I have a dry mouth, throat, or eyes
☐	I am concerned about how my teeth are wearing	☐	I want to keep every tooth for life
☐	I grind or clench my teeth (night or day)	☐	I would like to discuss cosmetic treatment
☐	I have pain or clicking in my jaw joint	☐	I would like to discuss aesthetic treament

Please elaborate (if appropriate) or highlight a concern not addressed above:

LAST NAME _____ FIRST NAME _____

MEDICAL HISTORY

It is important for us to understand your overall health and well-being. Conditions existing elsewhere in your body will affect your dental treatment. We will consult with your physician if required. Please be as thorough as possible.

PRIMARY CARE PRACTICE _____ PHONE_____

PRIMARY CARE PHYSICIAN _____DATE OF LAST MEDICAL EXAM _____ mm/yyyy

Have you been hospitalized within the last 5 years? ◯Yes ◯No Reason _____

Please list conditions for which you are **under the care of a physician**:

Please note any **changes in your general health** over the past 12 months:

Is it possible that you are pregnant? ◯Yes ◯No If you are pregnant, what is your due date? _____

Place a mark beside any condition you have experienced:

☐	Heart Trouble/Disease	☐	Stroke/TIA	☐	Arthritis/Gout	☐	Excessive Thirst
☐	Heart Murmur or MVP	☐	High Cholesterol	☐	Rheumatism	☐	Hypoglycemia
☐	Irregular Heart Beat	☐	Lung Disease	☐	Pain in Jaw Joints	☐	Liver Disease/Hepatitis
☐	Angina/Chest Pain	☐	Breathing Problem	☐	Cortisone Medicine	☐	Diabetes
☐	Heat Attack/Failure	☐	Shortness of Breath	☐	AIDS/HIV Positive	☐	Thyroid Disease
☐	Congenital Heart Disorder	☐	Frequent Cough	☐	Vertigo or Dizziness	☐	Parathyroid Disease
☐	Artificial Heart Valve	☐	Hay Fever/Allergy	☐	Epilepsy or Seizures	☐	Stomach/Intestinal Disease
☐	Heart Pace Maker	☐	Sinus Trouble	☐	Fainting	☐	Ulcers
☐	Heart Surgery	☐	Asthma	☐	Nervousness/Anxiety	☐	Recent Weight Loss
☐	High Blood Pressure	☐	Tobacco Use	☐	Psychiatric Care	☐	Frequent Diarrhea
☐	Low Blood Pressure	☐	Emphysema	☐	Memory Loss/Dementia	☐	Glaucoma
☐	Blood Disease	☐	Tumors or growths	☐	Scarlet Fever	☐	Hives or Rash
☐	Anemia	☐	Cancer	☐	Rheumatic Fever	☐	Recreational Drug Use
☐	Bleeding Problem	☐	Radiation Treatment	☐	Tuberculosis (TB)	☐	Drug Addiction
☐	Sickle Cell Disease	☐	Chemotherapy	☐	Cold Sores/Fever Blisters	☐	Alcohol Use
☐	Leukemia	☐	IV Bisphosphonates	☐	Swelling of Limbs	☐	Snoring/Sleep Apnea
☐	Recent Blood Transfusion	☐	Artificial Joint	☐	Yellow Jaundice	☐	Reflux Disease/GERD
☐	Bruise Easily	☐	Head/Neck Injury	☐	Kidney Problems		

Please **provide additional information** on your conditions (if req'd) and list **any other conditions** we should be aware of:

LAST NAME _____ FIRST NAME _____

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Are you taking blood thinners, daily aspirin, ibuprofen, naproxen or medications for arthritis? ◯Yes ◯No

Have you been told to pre-medicate with antibiotics prior to a dental procedure? ◯Yes ◯No

Please **list your allergies** (including medicines, metals, latex sensitivity, and others):

Please **list your medications** with dosage (prescribed, over-the-counter, herbal, supplement, vitamin, recreational)

SIGNATURE _____ **DATE** _____
mm/dd/yyyy

RELATIONSHIP TO PATIENT (if applicable) _____

HIPAA REQUIRED PRIVACY NOTIFICATION

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this Acknowledgement

I have received a copy of the Notice of Privacy Practices for Red Maple Dental.

PATIENT'S PRINTED NAME_____

PATIENT'S SIGNATURE_____ **DATE** _____
mm/dd/yyyy

FOR OFFICE USE ONLY. We attempted to obtain written acknowledgement of our Notice of Privacy Practices, but it could not be obtained because: