COFFEE FAMILY DENTAL PATIENT INFORMATION SHEET

Patient Name____ Date__________
Last First MI (Preferred Name)
State______

Address________________________________ City__________ Zip________

Sex (M or F)________ Marital Status__________ Birth Date:__________

Phone (Home):__________ Phone (Work):__________ Ext______ Cell #__________

Spouse Name: ____________________ Email Address: ____________________

Best time to call:______________ Social Security Number:______________

Employer Name:________________________ Phone #______________

Are any other immediate family members patients here? (Y N) If so, who?______________

Whom may we thank for referring you? ________________________________ *

Insurance Information

Subscribers Name____________________ SS#__________ Birth Date__________

Insurance Company__________________ Group #__________ Phone#__________

Mailing Address________________________ Employer Name______________

Responsible Party

Person responsible for account ______________________ Relationship__________

Address:____
Street City/State/Zip

Home #______________ Work #______________ Cell #______________

Health Information

Physicians Name________________________________ Phone#______________

Any Known Drug Allergies?____

---------- **Have you ever had or currently have any of the following? Please check those that apply:** -------------------

___Anaphylactic Rxns ___Epilepsy ___HIV Positive/AIDS ___Currently Pregnant ___Anemia ___Glaucoma

___Kidney Disease ___Penicillin Allergy ___Taking Aspirin ___Heart Attack ___Liver Disease ___Artificial Joints

___Respiratory Problems ___Heart Disease ___Mental Disorders ___Rheumatic Fever ___Arthritis ___Heart Murmur

___Mitral Valve Prolapse ___Sinus Problems ___Cancer ___Hepatitis ___Nervous Disorders ___Diabetes

___Sexually Transmitted Disease ___High Blood Pressure ___Pace maker ___Tuberculosis

Do you need to pre-medicate before your appointments due to joint replacement or heart related conditions? Y N

Are you currently taking any over the counter or prescription medication? Y N if so please list: ____

____ TURN OVER

Dental Information

What is the reason for your visit?_______________

How long has it been since your last dental visit?_______________

How long has it been since your last cleaning? _______________

Who was your previous dentist? _______________

Why did you leave your previous dentist?_______________

When were X-Rays last taken of your teeth?_______________

How frequently do you brush your teeth?_______________

Do you use a soft, medium, or hard bristle toothbrush?_______________

Do you have any concerns regarding your teeth?	Yes	No
Have you lost any teeth?	Yes	No
Do you clinch or grind your teeth?	Yes	No
Do you have any tooth, jaw or muscle discomfort?	Yes	No
Do you have frequent headaches?	Yes	No
Do you have a click, pop or other noise in the jaw joint?	Yes	No
Are your teeth sensitive to hot or cold?	Yes	No
Are any of your teeth uncomfortable to bite on?	Yes	No
Do your gums bleed when brushing or flossing your teeth?	Yes	No
Would you like information on whiting your teeth?	Yes	No
Are you interested in cosmetic bonding or straitening your teeth?	Yes	No
Have you ever been told you have gum disease?	Yes	No

Are there any conditions or concerns about your health that we need to discuss that have not been covered in the questionnaire?_______________

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I hereby authorize the release of any information, including the diagnosis and records of any treatment. X-rays, photographs, or examinations rendered, to my insurance company. I hereby authorize my insurance company to pay directly to Wm. Trevor Coffee, D.D.S., any proceeds payable under the terms of my insurance policy. **I understand that I am responsible for my dental bills.** I hereby authorize Wm. Trevor Coffee, D.D.S. to perform dental procedures on me, my minor child and/or family members. I will inform Dr. Coffee of any changes in my health.

Signature_______________ Relationship_______________

Date_______________