7802 Davenport St, Omaha, NE. 68114
402-281-4238

OFFICE USE ONLY
Entered: ______
Verified: ______

PATIENT INFORMATION

PATIENT LEGAL NAME: ________________________ (PLEASE PRINT) PREFERRED NAME: ____________ (PLEASE PRINT) DOB: ___ /___ /___

HOME ADDRESS: ______________________________ CITY: ____________ STATE: ____ ZIP: __________

PHONE NUMBERS:
Cell (__ __ __) __ __ __ - __ __ __ __ Home (__ __ __) __ __ __ - __ __ __ __ Work (__ __ __) __ __ __ - __ __ __ __

EMAIL ADDRESS: __________________________ EMPLOYER/SCHOOL: ______________________________

SOC SEC #: __ __ __ - __ __ - __ __ __ __ (ADULT ONLY) MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

EMERGENCY CONTACT: ____________________________ PHONE NUMBER: (__ __ __) - __ __ __ - __ __ __ __

PERSON RESPONSIBLE FOR PAYING THE BILL **IF SAME AS ABOVE LEAVE BLANK

RESPONSIBLE PERSON: ________________________________ (PLEASE PRINT) BIRTH DATE: ___ / ___ / ___

ADDRESS OF RESPONSIBLE PERSON: ________________________ CITY: __________ STATE: ___ ZIP: _________

BIRTH DATE: ___ / ___ / ___ SOC SEC # __ __ __ - __ __ - __ __ __ __

PHONE NUMBERS:
Cell (__ __ __) __ __ __ - __ __ __ __ Home (__ __ __) __ __ __ - __ __ __ __ Work (__ __ __) __ __ __ - __ __ __ __

PRIMARY DENTAL INSURANCE INFORMATION

DENTAL INSURANCE COMPANY NAME: ________________________ SUBSCRIBER ID #: ____________________
GROUP #: __________________________

IF THE FOLLOWING INFORMATION IS DIFFERENT THAN THE PATIENT INFORMATION PLEASE FILL IN

EMPLOYER: ___________________________________

SUBSCRIBER NAME: _____________________________ SUBSCRIBER DATE OF BIRTH: ___ / ___ / ___

SOC SEC #: __ __ __ - __ __ - __ __ __ __ ** IF THERE IS NOT A SUBSCRIBER ID # ON THE INSURANCE CARD THE SOCIAL SECURITY # IS NEEDED TO FILE YOUR INSURANCE CLAIM**

SECONDARY DENTAL INSURANCE INFORMATION

DENTAL INSURANCE COMPANY NAME: ________________________ SUBSCRIBER ID #: ____________________
GROUP #: __________________________

IF THE FOLLOWING INFORMATION IS DIFFERENT THAN THE PATIENT INFORMATION PLEASE FILL IN

EMPLOYER: ___________________________________

SUBSCRIBER NAME: _____________________________ SUBSCRIBER DATE OF BIRTH: ___ / ___ / ___

SOC SEC #: __ __ __ - __ __ - __ __ __ __ ** IF THERE IS NOT A SUBSCRIBER ID # ON THE INSURANCE CARD THE SOCIAL SECURITY # IS NEEDED TO FILE YOUR INSURANCE CLAIM**

How did you hear about our office? ☐ Website ☐ Insurance ☐ Referral ☐ Other ______________________
** If referred, who can we thank for referring you? ____

PATIENT/GUARDIAN SIGNATURE: ______________________________ **DATE:** ___ / ___ / ___

Patient Legal Name: ______________________________ **Preferred Name:** ________________ **DOB:** __/__/__
(PLEASE PRINT) (PLEASE PRINT)

DENTAL HISTORY (CHECK YES or NO AS NEEDED)

HAVE YOU HAD OR ARE YOU HAVING ANY OF THE FOLLOWING?

Are your apprehensive about dental treatment? __YES __NO
Have you had **Periodontal** (gum) treatment? __YES __NO
Do your **gums bleed**, **feel tender** or **irritated**? __YES __NO
Are you aware of **grinding or clenching**? __YES __NO
Do you have **frequent headaches**? __YES __NO

When was your last dental cleaning and exam? ___________
May we contact your previous dentist for records? __YES __NO If yes, DENTIST NAME: _________________________

PREMEDICATION PRIOR TO DENTAL TREATMENT

Have you ever been told to take an antibiotic premedication prior to dental treatment? __ YES __NO
If yes, what was the reason? ☐ **Joint Replacement** ☐ **Heart Valve** ☐ **Heart Murmur** ☐ **Other** ________________
If yes, what medication do you premedicate with? ☐ **Amoxicillin** ☐ **Clindamycin** ☐ **Other** ____________________
PRESCRIBING DOCTOR: ____

MEDICAL HISTORY

Are you under a **PHYSICIANS CARE**? If yes, for what? __YES __NO ____
____
PHYSICIAN'S NAME: ____
Have you been hospitalized or had a major operation? __YES __NO If yes ____________________________________
Have you had a serious head or neck injury? __YES __NO If yes ____
Are you taking any **MEDICATIONS, PILLS OR DRUGS**? **If yes, please list** __YES __ NO
____
Do you use controlled substances? __ YES __NO If yes ____
Do you or have you taken, **Phen-Fen or Redux**? __YES __NO ____
Do you smoke/use tobacco? __YES __NO
Women, are you ☐ Pregnant/Trying to get pregnant ☐ Nursing ☐ Taking an oral contraceptive

BLOOD THINNING MEDICATIONS

Are you taking **BLOOD THINNER** medication? __ YES __ NO
If yes, check which one:
☐ Warfarin ☐ Coumadin ☐ Eliquis ☐ Plavix
☐ Aspirin ☐ Other: ____________________
PRESCRIBING DOCTOR: ____

MEDICAL HISTORY CONTINUED

BONE BUILDING MEDICATION

Have you taken any **"BONE BUILDING"** medications? __YES __NO

If yes, please check which one/ones:

☐ Boniva ☐ Prolia ☐ Xgeva ☐ Reclast

☐ Zometa ☐ Actonel ☐ Medications that end with "MAB" ☐ Other___________

PRESCRIBING DOCTOR: ______________________________

____

ALLERGIES

Please check any of the following that you are allergic to:

☐ Aspirin ☐ Codeine ☐ Latex ☐ Local Anesthetics

☐ Metal ☐ Penicillin ☐ Sulfa Drugs ☐ Other: Please list

____

MEDICAL CONDITIONS

☐ ACID REFLUX
☐ AIDS/HIV POSITIVE
☐ ALZHEIMER'S DISEASE
☐ ANAPHYLAXIS
☐ ARTIFICIAL HEART VALVE
☐ ARTIFICIAL JOINT
☐ ASTHMA
☐ BLOOD DISEASE
☐ BLOOD TRANSFUSION
☐ BREATHING PROBLEMS
☐ BRUISE EASILY
☐ CANCER/CHEMOTHERAPY/RADIATION
☐ COLD SORES/FEVER BLISTERS
☐ CONGENITAL HEART DISORDER
☐ DIABETES
☐ EPILEPSY/SIEZURES
☐ HAY FEVER
☐ HEART DISEASE
☐ HEART MURMUR
☐ HEART PACEMAKER
☐ HEPATITIS A, B OR C
☐ HIGH/LOW BLOOD PRESSURE
☐ HIGH CHOLESTEROL
☐ KIDNEY PROBLEMS
☐ LIVER DISEASE
☐ MITRAL VALVE PROLAPSE
☐ OSTEOPOROSIS
☐ RHEUMATISM
☐ RHEUMATIC FEVER
☐ SCARLET FEVER
☐ STOMACH/INTESTINAL DISEASE
☐ STROKE
☐ THYROID DISEASE
☐ TUBERCULOSIS
☐ OTHER

The undersigned hereby attests that the information is complete and accurate.

____ ____

PRINT PATIENT NAME **SIGNATURE of PATIENT, PARENT OR GUARDIAN**

____

DATE

OFFICE USE ONLY
Entered: ___
Reviewed____