Welcome to **Pike Family Dentistry**

Since 1909, General and Cosmetic

Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

Patient Information

Date _____ Soc. Sec. # _____ Birthdate _____

Name _____
Last Name First Name Initial

Address _____ Home Phone _____

City _____ State _____ Zip _____

Sex: ❑ M ❑ F ❑ Minor ❑ Single ❑ Married ❑ Long Term Partner ❑ Divorced ❑ Widowed ❑ Separated

Employer _____ Business Phone _____

Business Address _____ Occupation _____

Who should we thank for referring you? _____

In case of emergency, who should we contact? _____ Phone _____

Primary Dental Insurance

Person Responsible for Account _____
Last Name First Name Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Responsible Party Employed By _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

Additional Insurance

Insured Name _____
Last Name First Name Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Insured Employed By _____ Business Phone _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

Please complete on reverse side

Dental History

Former Dentist _____ Date of Last X-Rays _____

City, State _____ How Often Do You Floss? _____

Date of Last Dental Visit _____ How Often Do You Brush? _____

Please check all that apply:

- ❑ Bad Breath
- ❑ Bleeding Gums
- ❑ Blisters on Lips or Mouth
- ❑ Finger Nail Biting
- ❑ Grinding Teeth
- ❑ Lip or Cheek Biting
- ❑ Loose Teeth or Broken Fillings
- ❑ Orthodontic Treatment
- ❑ Pain Around Ear
- ❑ Periodontal Treatment
- ❑ Sensitivity to Cold
- ❑ Sensitivity to Heat
- ❑ Sensitivity to Sweets
- ❑ Sensitivity When Biting
- ❑ Frequent Headaches
- ❑ Jaw, Head or Neck Injuries
- ❑ Jaw Difficulty: Clicking and/or Pain
- ❑ Tooth Pain

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	❑ Yes	❑ No
Have you ever been hospitalized or had a major operation?	❑ Yes	❑ No
Have you ever had a serious head or neck injury?	❑ Yes	❑ No
Are you taking any medications, pills or drugs?	❑ Yes	❑ No
Do you take, or have you taken, Phen-Fen or Redux?	❑ Yes	❑ No
Are you on a special diet?	❑ Yes	❑ No
Do you use tobacco?	❑ Yes	❑ No
Do you use controlled substances?	❑ Yes	❑ No

Women: Are you

❑ Pregnant/Trying to get pregnant? ❑ Nursing ?

❑ Taking oral contraceptives?

Are you allergic to any of the following?

❑ Aspirin ❑ Local Anesthetics ❑ Metal

❑ Penicillin ❑ Acrylic ❑ Latex

❑ Codeine ❑ Other

(If other, please explain): _____

Do you have, or have you had, any of the following? _____

AIDS/HIV Positive	❑Yes ❑No	Cortisone Medicine	❑Yes ❑No	Hemophilia	❑Yes ❑No	Renal Dialysis	❑Yes ❑No
Alzheimer's Disease	❑Yes ❑No	Diabetes	❑Yes ❑No	Hepatitis A	❑Yes ❑No	Rheumatic Fever	❑Yes ❑No
Anaphylaxis	❑Yes ❑No	Drug Addiction	❑Yes ❑No	Hepatitis B or C	❑Yes ❑No	Rheumatism	❑Yes ❑No
Anemia	❑Yes ❑No	Easily Winded	❑Yes ❑No	Herpes	❑Yes ❑No	Scarlet Fever	❑Yes ❑No
Angina	❑Yes ❑No	Emphysema	❑Yes ❑No	High Blood Pressure	❑Yes ❑No	Shingles	❑Yes ❑No
Arthritis/Gout	❑Yes ❑No	Epilepsy or Seizures	❑Yes ❑No	Hives or Rash	❑Yes ❑No	Sickle Cell Disease	❑Yes ❑No
Artificial Heart Valve	❑Yes ❑No	Excessive Bleeding	❑Yes ❑No	Hypoglycemia	❑Yes ❑No	Sinus Trouble	❑Yes ❑No
Artificial Joint	❑Yes ❑No	Excessive Thirst	❑Yes ❑No	Irregular Heartbeat	❑Yes ❑No	Spina Bifida	❑Yes ❑No
Asthma	❑Yes ❑No	Fainting Spells/Dizziness	❑Yes ❑No	Kidney Problems	❑Yes ❑No	Stomach/Intestinal Disease	❑Yes ❑No
Blood Disease	❑Yes ❑No	Frequent Cough	❑Yes ❑No	Leukemia	❑Yes ❑No	Stroke	❑Yes ❑No
Blood Transfusion	❑Yes ❑No	Frequent Diarrhea	❑Yes ❑No	Liver Disease	❑Yes ❑No	Swelling of Limbs	❑Yes ❑No
Breathing Problem	❑Yes ❑No	Frequent Headaches	❑Yes ❑No	Low Blood Pressure	❑Yes ❑No	Thyroid Disease	❑Yes ❑No
Bruise Easily	❑Yes ❑No	Genital Herpes	❑Yes ❑No	Lung Disease	❑Yes ❑No	Tonsillitis	❑Yes ❑No
Cancer	❑Yes ❑No	Glaucoma	❑Yes ❑No	Mitral Value Prolapse	❑Yes ❑No	Tuberculosis	❑Yes ❑No
Chemotherapy	❑Yes ❑No	Hay Fever	❑Yes ❑No	Pain in Jaw Joints	❑Yes ❑No	Tumors or Growths	❑Yes ❑No
Chest Pains	❑Yes ❑No	Heart Attack/Failure	❑Yes ❑No	Parathyroid Disease	❑Yes ❑No	Ulcers	❑Yes ❑No
Cold Sores/Fever Blisters	❑Yes ❑No	Heart Murmur	❑Yes ❑No	Psychiatric Care	❑Yes ❑No	Venereal Disease	❑Yes ❑No
Congenital Heart Disorder	❑Yes ❑No	Heart Pace Maker	❑Yes ❑No	Radiation Treatments	❑Yes ❑No	Yellow Jaundice	❑Yes ❑No
Convulsions	❑Yes ❑No	Heart Trouble/Disease	❑Yes ❑No	Recent Weight Loss	❑Yes ❑No		

Have you ever had any serious illness not listed above? ❑Yes ❑No

Assignment and Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

I hereby authorize payment directly to _____ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Patient, Parent, or Guardian _____ **Date** _____