StoneRidgeDental by Monarrez

Date: _____

We would like to extend a warm welcome and thank you for choosing our dental team for your dental care. We will always strive to provide you with the best possible dental care and attention. Please fill out this form in its entirety. If you have any questions or need assistance, please ask us. We are always happy to help you.

Please print:

## Patient Information (CONFIDENTIAL)

Name: _____ Cell Phone: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Age: _____ Sex: ☐M ☐F Social Security Number: _____

Check appropriate box: ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Patient's Employer/School: _____ Work Phone: _____

Occupation: _____ Years at Current Employer: _____

Email: _____ Emergency Contact: _____ Cell: _____

Whom may we thank for referring you? _____ or ☐Google ☐Facebook ☐TV ☐Insurance

Preferred method of contact: ☐ Phone Call ☐ Text ☐ Email

## Responsible Party (Ex: Parents, Spouse, Caregiver, Nursing home, P.O.A, etc.)

Name of person responsible for this account: _____

Relationship to Patient: _____ Cell Phone: _____

Address: _____

Social Security Number: _____ Birth date: _____

Employer: _____ Work phone: _____

Is this person currently a patient in our office? ☐Yes ☐No

## Dental Insurance Information:

Name of Insured: _____ Relationship to Patient: _____

Subscriber's Birth date: _____ Member ID: _____

Name of Employer: _____ Work Phone: _____

Name of Dental Insurance: _____ Group Number: _____

Insurance Address: _____ City: _____ State: _____ Zip code: _____

## Do you have additional dental insurance? ☐Yes ☐No If yes, please complete the following:

Name of Insured: _____ Relationship to Patient: _____

Subscriber's Birth date: _____ Member ID: _____

Name of Employer: _____ Work Phone: _____

Name of Dental Insurance _____ Group Number: _____

Insurance Address: _____ City: _____ State: _____ Zip code: _____

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## Dental History

How can we improve your smile today? _____

Are you in any dental discomfort? _____

Previous dental provider: _____

Date of last dental care: _____ Date of last x-rays: _____

Have you had problems with any of the following?

Y ☐ N ☐ Bad Breath
Y ☐ N ☐ Bleeding Gums
Y ☐ N ☐ Broken Fillings
Y ☐ N ☐ Clicking/Popping Jaw
Y ☐ N ☐ Grinding/Clenching
Y ☐ N ☐ Hot/Cold Sensitivity
Y ☐ N ☐ Loose Teeth
Y ☐ N ☐ Difficulty Chewing
Y ☐ N ☐ Missing Teeth
Y ☐ N ☐ Sweets Sensitivity
Y ☐ N ☐ Sensitivity when biting
Y ☐ N ☐ Sores/Growths in mouth

How do you feel about the appearance of your teeth? _____

Have you experienced an adverse reaction during/in conjunction with a medical/dental procedure? Y☐ N☐

Any other important information about your dental health or previous treatment: _____

## Medical History

Physician's Name: _____ Date of last Physician visit: _____ Phone: _____

Are you currently under physician care? If yes, describe: _____

Have you had any serious illnesses or operations? If yes, please describe: _____

Are you allergic to any medication? _____

Please list ALL medications you currently take: _____

_____

Have you ever used biphosphonate medication? (Brand names include Fosamax, Actonel, Atelvia, Didronel, and Boniva) Y☐ N☐

Women: Are you pregnant? Y ☐ N ☐ Nursing? Y ☐ N ☐ Taking birth control pills? Y ☐ N ☐

Please check **Yes** or **No** if you've had any of the following. PLEASE DO NOT LEAVE ANY UNCHECKED:

Y☐ N☐ AIDS/HIV Positive
Y☐ N☐ Anaphylaxis
Y☐ N☐ Anemia
Y☐ N☐ Arthritis, Rheumatism
Y☐ N☐ Artificial Heart Valves
Y☐ N☐ Artificial Joints
Y☐ N☐ Asthma
Y☐ N☐ Atrial Fibrilation
Y☐ N☐ Atopic (Allergy Prone)
Y☐ N☐ Back Problems
Y☐ N☐ Blood Disease
Y☐ N☐ Cancer
Y☐ N☐ Chemical Dependency
Y☐ N☐ Chemotherapy
Y☐ N☐ Circulatory Problems
Y☐ N☐ Cortisone Treatments
Y☐ N☐ Cough (persistent)
Y☐ N☐ Cough up blood
Y☐ N☐ Diabetes
Y☐ N☐ Epilepsy
Y☐ N☐ Excessive Bleeding
Y☐ N☐ Fainting
Y☐ N☐ Food Allergies
Y☐ N☐ Glaucoma
Y☐ N☐ Headaches
Y☐ N☐ Heart Murmur
Y☐ N☐ Heart Problems
Y☐ N☐ High Cholesterol
Describe: _____
Y☐ N☐ Hemophilia/Abnormal Bleeding
Y☐ N☐ Herpes
Y☐ N☐ Hepatitis
Y☐ N☐ High Blood Pressure
Y☐ N☐ Jaw Pain
Y☐ N☐ Kidney Disease
Y☐ N☐ Liver Disease
Y☐ N☐ Material Allergies
Y☐ N☐ (latex, wool, metal, chemicals)
Y☐ N☐ Mitral Valve Prolapse
Y☐ N☐ Nervous Problems
Y☐ N☐ Pacemaker/Heart Surgery
Y☐ N☐ Psychiatric Care
Y☐ N☐ Rapid Weight Change
Y☐ N☐ Radiation Treatment
Y☐ N☐ Respiratory Disease
Y☐ N☐ Rheumatic/Scarlet Fever
Y☐ N☐ Shingles
Y☐ N☐ Shortness of Breath
Y☐ N☐ Skin Rash
Y☐ N☐ Spina Bifida
Y☐ N☐ Stroke
Y☐ N☐ Surgical Implants
Y☐ N☐ Swelling of feet or ankles
Y☐ N☐ Thyroid disease
Y☐ N☐ Tobacco Habit
Y☐ N☐ Tonsillitis
Y☐ N☐ Tuberculosis
Y☐ N☐ Ulcers/Colitis
Y☐ N☐ Venereal Disease
Other: _____
_____
_____
_____

## Authorization and Release

I confirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform the office of any changes in my medical status. I understand this information will be used by the dentist to help determine appropriate and healthful treatment.

My method of payment will be _____. I certify that I am covered by _____ Insurance Company and I assign directly to this dental office all insurance benefits, otherwise payable to me. I understand that I am responsible for payment of service rendered and also responsible for any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electric. By signing below, I have read and understand all of the above.

Signature: _____ Date: _____