ROCKCANYON DENTISTRY

Patient Information:

Today's Date:________________

Responsible Party: (person paying the bill) O Yes O No

First name ____________________________ M.I _______ Last Name ____________________________
Preferred Name__________________________ Date of Birth ________/________/_________ SEX: M / F
Social Security #__________-__________-__________ Employer Name ____________________
Full Time Student O Yes O No **Marital Status**: O Single O Married O Divorced O Widowed

Mailing Address:

Street/ PO Box ____________________________________ City____________________________________
State ____________________ Zip __________________

Phone Numbers

Home ________-________-________ Cell ________-________-________ Work ______-______-________
Email:____

Reminders: Texts: O Yes O No **Email:** O Yes O No

Spouses Name ___________________________ Cell phone #____________________________
Email:__________________________________ Spouses Employer ____________________________

Emergency Contact:

Name:________________________ Home #_____________________Cell #________________________
Relationship to patient ______________________________

Responsible Party: *Please complete this section if someone other then the patient is responsible for the bill

Name of Person: First______________________________ Last ________________________________
Street Address ____ City ____________________________
State __________________________ Zip_______________
Home phone # _____________________________ Cell phone #_________________________________

Insurance Information:

Responsible Party: (person responsible for the bill) O Yes O No

Subscribers Information:

Policy Holder's Name____ Date of Birth________/______/______
Phone Number ________-_________-__________ Relations to Patient ___________________________
Group Id #_____________________________ Member Id/ SSN #______________________________

Subscribers address:

Street:________________________________ City______________________ Zip_____________
Employer Name: ________________________________Phone #___________________________

Insurance Company: Name____

Insurance Phone # __________-__________-__________

Insurance Address:

Street/ PO Box:____ City______________________________
State __________________________ Zip _________________

Secondary Insurance Information:

Subscriber Policy holder Name______________________ _________ Date of Birth________/______/________
Subscriber Phone Number ________-________-__________ Relations to Patient _________________________
Group Id #________________________________ Member Id/ SSN #________________________________

Subscribers address:

Street:________________________________ City________________________ Zip______________
Employer Name: ____________________________________Phone # ___________________________

Insurance Company: Name____

Insurance Phone # __________-__________-__________

Insurance Address:

Street/ PO Box:____ City______________________________
State __________________________ Zip __________________

All Information on this form is accurate to the best of my knowledge.

Signature:____ Date_________________________

MEDICAL HISTORY

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

Are you under the care of a physician?
O Yes O No If yes, explain: ____________________

Have you ever been hospitalized or had a major surgery?
O Yes O No If yes, explain: ____________________

Have you ever had a serious head or neck injury?
O Yes O No If yes, explain: ____________________

Are you taking any medications, pills, or drugs? You may list them below.
O Yes O No If yes, explain: ____________________

Have you ever taken, Bisphosphonales, such as Fosamax, Boniva, Actenol?
O Yes O No If yes, explain: ____________________

Medication List

____
____
____
____
____
____
____

Women: Are you…..

Pregnant/trying to get pregnant? O Yes O No # of weeks pregnant____________
Taking oral contraceptives? O Yes O No Nursing? O Yes O No

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Aspirin O Yes O No Penicillin O Yes O No Codeine O Yes O No Local Anesthetics O Yes O No
Acrylic O Yes O No Metal O Yes O No Latex O Yes O No Sulfa Drugs O Yes O No
If your answer is yes to any of these questions, please explain reactions____________________
Others (please explain)____________________

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

AIDS/HIV Positive	O Yes O No	Epilepsy or Seizures	O Yes O No	Lung Disease	O Yes O No
Alzheimer's Disease	O Yes O No	Excessive Thirsty	O Yes O No	Mitral Valve Prolapsed	O Yes O No
Anaphylaxis	O Yes O No	Fainting/Dizziness	O Yes O No	Osteoporosis	O Yes O No
Anemia	O Yes O No	Frequent Cough	O Yes O No	Pain In Jaw Joints	O Yes O No
Angina	O Yes O No	Frequent Diarrhea	O Yes O No	Parathyroid Disease	O Yes O No
Arthritis/Gout	O Yes O No	Frequent Headaches	O Yes O No	Psychiatric Care	O Yes O No
Artificial Heart Valve	O Yes O No	Genital Herpes	O Yes O No	Radiation Treatments	O Yes O No
Asthma	O Yes O No	Glaucoma	O Yes O No	Recent Weight Loss	O Yes O No
Blood Disease	O Yes O No	Hay Fever	O Yes O No	Renal Dialysis	O Yes O No
Blood Thinners	O Yes O No	Heart Attack/Failure	O Yes O No	Rheumatic Fever	O Yes O No
Blood Transfusion	O Yes O No	Heart Murmur	O Yes O No	Rheumatism	O Yes O No
Breathing Problem	O Yes O No	Heart Pacemaker	O Yes O No	Scarlet Fever	O Yes O No
Bruise Easy	O Yes O No	Heart Disease/ trouble	O Yes O No	Shingles	O Yes O No
Cancer	O Yes O No	Hemophilia	O Yes O No	Sickle Cell Disease	O Yes O No
Chemotherapy	O Yes O No	Hepatitis A	O Yes O No	Sinus Trouble	O Yes O No
Chest Pains	O Yes O No	Hepatitis B or C	O Yes O No	Spina Bifida	O Yes O No
Cold Sores	O Yes O No	Herpes	O Yes O No	Stomach Disease (GI)	O Yes O No
Congenital Heart		High Blood Pressure	O Yes O No	Stroke	O Yes O No
Disorder	O Yes O No	High Cholesterol	O Yes O No	Swelling of Limbs	O Yes O No
Cortisone Medicine	O Yes O No	Hives or Rash	O Yes O No	Thyroid Disease	O Yes O No
Disorder	O Yes O No	Hypoglycemia	O Yes O No	Tonsillitis	O Yes O No
Convulsions	O Yes O No	Irregular Heart Boat	O Yes O No	Tuberculosis	O Yes O No
Diabetes	O Yes O No	Kidney Problems	O Yes O No	Tumor or Growth	O Yes O No
Drug Addiction	O Yes O No	Leukemia	O Yes O No	Ulcers	O Yes O No
Easily winded	O Yes O No	Liver Disease	O Yes O No	Venereal Disease	O Yes O No
Emphysema	O Yes O No	Low Blood Pressure	O Yes O No	Yellow Jaundice	O Yes O No

Have you over had any other illness not listed above? ____________________
____
____

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 mine (patients) health. It is my responsibility to inform the dental office of any changes in medical Status.

SIGNATURE OF PATIENT, PARENT or GUARDIAN____________________DATE ___________