



Marnie C. Bauer, D.M.D.

Welcome!

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name: _____ Soc. Sec. #: _____
Last Name First Name Initial

Sex: M F Birth Date: _____ Age: _____

Single Married Widowed Separated Divorced Employer: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-Mail: _____

Responsible Party Name: _____
(If Under 18 years of age) Last Name First Name Initial

Soc. Sec. #: _____ Birth Date: _____ Relation to Pt: _____

Notify in case of Emergency _____ Home Phone: _____

Relationship to Patient: _____ Other Phone: _____

Whom may we thank for referring you? _____ Home Phone: _____

Insurance Information

Subscriber Name: _____ Birth Date: _____

Subscriber Soc. Sec. # _____ Self Spouse Child Other

Employer: _____ Work Phone: _____

Insurance Company Name: _____ Phone: _____

Group # _____

Dental History

What would you like us to do today? _____

Are you having any dental discomfort? _____

Former Dentist: _____ Phone: _____

Why did you seek us out to be your dentist? _____

What kind of toothbrush do you use? _____

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

Check if you have had any problems with the following:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Periodontal Disease | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Grinding or clenching teeth | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to hot | <input type="checkbox"/> Sores or growths in mouth |

How often do you brush? _____ Floss: _____

If you could change anything about your smile, what would you change? _____

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

Other information about your dental health or previous treatment: _____

I have avoided dental care in the past because: _____

PLEASE COMPLETE BOTH SIDES

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.

Please explain any "yes" answers in the space provided

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

Women: Are you
 Pregnant / Trying to get pregnant?
 Nursing?
 Taking Oral Contraceptives?

Are you allergic to any of the following:
 Aspirin Penicillin Codeine Acrylic Latex Local Anesthetics Other _____

Do you have or had you had any of the following? Please check all "yes" answers

<input type="checkbox"/> Aids/HIV Positive	<input type="checkbox"/> Cold Sores/Fever Blisters	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Stomach/Intestinal Disease
<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Congenital Heart Disorder	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Spinal Bifida
<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Heart Attack/Failure	<input type="checkbox"/> MRSA	<input type="checkbox"/> Stroke
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cortisone Medicine	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Swelling of limbs
<input type="checkbox"/> Angina	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Pace Maker	<input type="checkbox"/> Pain in Jaw Joints	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Arthritis/Gout	<input type="checkbox"/> Drug / Alcohol Addiction	<input type="checkbox"/> Heart Trouble/Disease	<input type="checkbox"/> Parathyroid Disease	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Easily Winded	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Artificial Joint	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Radiation Treatments	<input type="checkbox"/> Tumors or Growths
<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy or Seizures	<input type="checkbox"/> Hepatitis B or C	<input type="checkbox"/> Recent weight gain	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Herpes	<input type="checkbox"/> Renal Dialysis	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Yellow Jaundice
<input type="checkbox"/> Breathing Problem	<input type="checkbox"/> Fainting Spells/Dizziness	<input type="checkbox"/> Hives or Rash	<input type="checkbox"/> Rheumatism	
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Frequent Cough	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Scarlet Fever	
<input type="checkbox"/> Cancer	<input type="checkbox"/> Frequent Diarrhea	<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> Shingles	
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Sickle Cell Disease	
<input type="checkbox"/> Chest Pains	<input type="checkbox"/> Genital Herpes	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Sinus Trouble	

Other medical condition: please explain _____

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

Explanation of any "yes" answers: _____

Staff Use: Blood Pressure: _____ Pulse: _____

Dr. Signature: _____ Date: _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I agree to dental examination and any necessary records that are necessary for an accurate diagnosis. I authorize you to file on my behalf insurance claims, (if applicable) and understand I am responsible for any outstanding balance after my insurance company has paid the dental office.

Signature: _____ Date: _____

I authorize the dentist to use any treatment records, x-rays, models or photos for scientific, teaching or promotional purposes.

Signature: _____ Date: _____

Payment is due in full at time of treatment