Nicole Helfrich, DDS

Date: _____

PERSONAL INFORMATION

Patient Name: _____ _____ _____ ☐ Male ☐ Female
FIRST NAME M.I. LAST NAME

Address: _____ _____ _____ _____
STREET CITY STATE ZIP CODE

Age: _____ Date of Birth: _____ S.S. # _____ ☐ Single ☐ Married ☐ Minor

E-mail: _____ ☐ Separated ☐ Divorced ☐ Widowed

Phone: Home: (____)_____ Cell: (____)_____ Work: (____)_____

Where do you prefer to receive calls? ☐ Home ☐ Cell ☐ Work

Patient Employer/School: _____ Occupation: _____

Emergency Contact: _____ (____)_____ _____
NAME PHONE RELATION

Whom may we thank for referring you? _____

SPOUSE OR RESPONSIBLE PARTY INFORMATION

Spouse or Responsible party: _____ _____ _____ Relation to Patient: _____
FIRST NAME M.I. LAST NAME

Address (if different from patient): _____ _____ _____ _____
STREET CITY STATE ZIP CODE

Date of Birth: _____ S.S. # _____ Phone: (____)_____

Employer/School: _____ Occupation: _____

PRIMARY DENTAL INSURANCE

Subscriber's Name: _____ S.S. # _____

Employer Name: _____ Insurance Company: _____

Group # _____ Subscriber # _____

Names of other dependents covered under this plan: _____

SECONDARY DENTAL INSURANCE

Subscriber's Name: _____ S.S. # _____

Employer Name: _____ Insurance Company: _____

Group # _____ Subscriber # _____

Names of other dependents covered under this plan: _____

MEDICAL HISTORY

Physician's Name: _____ Date of Last Visit: _____

Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain: _____

Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain: _____

MEDICAL HISTORY (continued)

Have you had any serious illnesses or operations? ☐ Yes ☐ No

If yes, please explain: _____

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, please explain: _____

WOMEN: Are you pregnant or nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Are you allergic to any of the following? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Latex ☐ Anesthetic ☐ Other

If so, please explain: _____

Are you or have you ever taken medications containing bisphosphonates (Fosamax, Actonel, Aredia, etc.)?

☐ Yes ☐ No

Do you smoke or use tobacco? ☐ Yes ☐ No If yes, how much daily? _____

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

☐ Acid reflux	☐ Cortisone Treatments	☐ Heart Pacemaker	☐ Pain in Jaw Joints
☐ AIDS/HIV positive	☐ Cold Sores	☐ Heart Disease	☐ Rheumatic Fever
☐ Alzheimer's disease	☐ Congenital Heart Disorder	☐ Hepatitis A	☐ Shortness of Breath
☐ Anemia	☐ Diabetes	☐ Hepatitis B	☐ Sickle Cell Disease
☐ Angina	☐ Drug Addiction	☐ Hepatitis C	☐ Sinus Trouble
☐ Arthritis	☐ Emphysema	☐ High Blood Pressure	☐ Stroke
☐ Artificial Heart Valve	☐ Epilepsy or Seizures	☐ Hypoglycemia	☐ Thyroid Disease
☐ Artificial Joints	☐ Excessive Thirst	☐ Irregular Heart Beat	☐ Tonsillitis
☐ Asthma	☐ Fainting Spells/Dizziness	☐ Kidney Problems	☐ Tuberculosis
☐ Back Problems	☐ Frequent Headaches	☐ Leukemia	☐ Tumors or Growths
☐ Blood Disease	☐ Hay Fever	☐ Liver Disease	☐ Ulcers
☐ Blood Transfusion	☐ Heart Attack/Failure	☐ Lung Disease	☐ Venereal Disease
☐ Cancer	☐ Heart Murmur	☐ Mitral Valve Prolapse	☐ Yellow Jaundices

Please list any medications that you are currently taking: _____

_____

DENTAL HISTORY

Reason for today's visit: _____

Former dentist: _____ Date of last dental visit: _____

Does dental treatment make you nervous? ☐ Yes ☐ Moderately ☐ Slightly ☐ No

Have you had problems with any of the following?

☐ Bleeding gums	☐ Food collection between teeth	☐ Sensitivity to sweets
☐ Broken fillings	☐ Grinding/Clenching of teeth	☐ Sensitivity when biting
☐ Clicking or popping jaw	☐ Loose teeth	☐ Sores or growths in your mouth
☐ Crowded or crooked teeth	☐ Periodontal treatment	
☐ Dark or discolored teeth	☐ Sensitivity to hot or cold	

Are you happy with your smile? ☐ Yes ☐ No If no, what would you change? _____

Are you satisfied with your bite? ☐ Yes ☐ No If no, what would you change? _____

AUTHORIZATION & CONSENT

I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize Dr. Helfrich to disclose my health care information to my insurance company for the purposes of obtaining payment for services and determining insurance benefits. I hereby authorize Dr. Helfrich and staff to render my dental treatment.

_____ _____

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN DATE