Name:_____

Birthdate:_____ **Age:**_____

Central Dental

Michelle L. Hasbrook, DMD

120 Atwater St. N
Monmouth, OR 97361
(503) 838-2998

DENTAL HISTORY

Reason for today's visit:_____

Former Dentist:_____City:_____

Date of last dental visit:_____Date of last dental X-rays:_____

Please check if you have or have had any of the following:

___ Bad breath	___ Sensitivity to sweets	___ Sensitivity when biting
___ Bleeding gums	___ Clicking or popping jaw	___ Sensitivity to hot & cold
___ Grinding teeth	___ Loose teeth or broken fillings	___ Food collection between teeth
___ Pain in mouth	___ Periodontal treatment	___ Sores or growths in your mouth

Are you satisfied with the appearance of your teeth?_____

Please rate your smile: 0 1 2 3 4 5 6 7 8 9 10

MEDICAL HISTORY

Physician's name:_____ Date of last physical:_____

Have you had any serious illness or operations? __ No / Yes__ If Yes, describe:_____

(Women) Are you pregnant? __No / Yes__ Nursing? __No / Yes__ Taking birth control pills? __No / Yes __

Do you require antibiotics prior to dental treatment? ___No / Yes___

Please check if you have or have had any of the following:

__ AIDS	__Circulatory problems	__Hepatitis	__Respiratory diseases
__ Alzheimers, dementia, memory loss	__Cortisone treatments	__High blood pressure	__Radiation treatment
		__High cholesterol	__Rheumatic Fever
__Anemia	__Cough, persistent	__HIV Positive	__Shortness of breath
__Artificial joints	__Diabetes	__Kidney disease	__Skin rash
__Artificial heart valve	__Epilepsy	__Latex allergy	__Stroke
__Asthma	__Fainting	__Liver disease	__Thyroid problems
__Back problems	__Fibromyalgia	__Mitral valve prolapse	__Tobacco habit
__Blood disease	__Glaucoma	__Nervous problems	__Tonsillitis
__Cancer	__Headaches	__Osteoporosis	__Tuberculosis
__Chemical dependency	__Heart murmur	__Pacemaker	__Ulcer
	__Heart problems	__Parkinson's disease	__Venereal disease
__Chemotherapy	__Hemophilia	__Psychiatric care	

Other? Describe:_____

MEDICATIONS:_____ **ALLERGIES:**_____

_____ _____

_____ _____

AUTHORIZATION AND RELEASE:

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist, insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

_____ _____

Signature of patient, or of parent if patient is a minor Date

Payment is due in full at time of treatment unless prior arrangements have been approved.

PATIENT INFORMATION

Patient's Name:_____ Birthdate:_____ Age:_____

Address:_____City:_____State:____ Zip:_____

Home Phone:_____ Daytime phone:_____ Mobile:_____

Email: _____

Whom may we thank for referring you to our office?_____

RESPONSIBLE PARTY INFORMATION

Name:_____Marital Status:_____

Address:_____City:_____State:____ Zip:_____

Mailing address:_____

Home Phone:_____ Daytime phone:_____ Mobile:_____

Relationship to Patient:_____ Birthdate:_____ Social Security No:_____

Employer:_____Occupation:_____No. Years Employed:_____

Spouse's Name:_____

Employer:_____Occupation:_____No. Years Employed:_____

Daytime Phone:_____Birthdate:_____ Social Security No:_____

INSURANCE INFORMATION

Policy Holder's Name:_____ Birthdate:_____

Address:_____City:_____State:____ Zip:_____

Home Phone:_____ Daytime phone:_____ Mobile:_____

Insurance Company:_____Insurance ID No:_____ Group No:_____

Insurance Co. Address:_____Insurance Co. Phone:_____

Policy Holder's Employer:_____

Does the patient have dual coverage? ___No / Yes___ If Yes, please complete the information below.

Policy Holder's Name:_____and Insurance ID No:_____

Insurance Company:_____Group No:_____Union Local No:_____

Insurance Co. Address:_____Insurance Co. Phone:_____

EMERGENCY INFORMATION

Name of nearest relative not living with patient:_____

Complete address:_____

Phone No:_____Relationship:_____

_____ _____

Patient Signature, or Parent's signature if patient is a minor **Date**