Alpine Family Dental

101 Westview Park Place
Kalispell, MT 59901
406-752-1107

Patient Information

Last Name:_____ **First Name:** _____ **Middle Initial:**_____ **Date of Birth:**_____

Preferred to be called: _____

Mailing Address: _____ **City, State, Zip:** _____

Cell Phone:_____**Work Phone:**_____**Home Phone:**_____

Email:_____ **SS#:**_____

Pharmacy:_____ **Primary Physician :**_____

How would you prefer to be contacted for appointment reminders? Text Email Phone (circle all that apply)

Patient Is:

[ ] Policy Holder for Insurance
[ ] Responsible Party

Emergency Contact Name:_____ **Phone #:**_____

How did you hear about our office: [ ] Internet Search [ ] Patient Referral [ ] Website [ ] Other:_____

If you were referred by another guest, who may we thank?_____

Responsible Party Information

(Please fill out if different from patient, responsible party must be present to sign financial agreement)

[ ] Same As Above

Last Name:_____ **First Name:** _____ **Middle Initial:**_____ **Date of Birth:**_____

Preferred to be called: _____

Mailing Address: _____ **City, State, Zip:** _____

Cell Phone:_____**Work Phone:**_____**Home Phone:**_____

Email:_____ **SS#:**_____

Insurance Information

Primary Insurance Company: _____**Address:** _____

City:_____ **State:**_____ **Zip:**_____**Phone:**_____**Relation to Patient:**_____

Policy Holder Name:_____ **Birth Date:**_____ **Members ID #:**_____

Employer Name:_____**Group # or Policy #:**_____

Secondary Insurance Company:_____ **Address:** _____

City:_____**State:**_____ **Zip:**_____**Phone:**_____**Relation to Patient:**_____

Policy Holder Name:_____ **Birth Date:**_____ **Members ID #:**_____

Employer Name:_____**Group # or Policy #:**_____

Dental Health History

Name of your former Dentist :_____ **How long since you were last seen?** _____

What prompted you to seek dental care at this time?_____

Are you having discomfort at this time? If so describe:_____

Is keeping your teeth important to you? [Y] [N] If yes, why?_____

On a scale of 1-10, 10 being the best, where would you rate your smile?_____

On a scale of 1-10, 10 being the best, where would you rate your oral health?_____

Have you experienced any of the following problems:

[Y] [N] Bleeding Gums

[Y] [N] Have you or your parents suffer(ed) from gum disease?

[Y] [N] Bad Breath or sour taste in mouth

[Y] [N] Burning sensation in mouth

[Y] [N] Soreness in jaw

[Y] [N] Is it hard for you to open wide?

[Y] [N] Clicking, popping or other noises in jaw

[Y] [N] Ever been injured in your mouth or head?

[Y] [N] Do you or your parents wear dentures/partials?

[Y] [N] Oral surgery of any kind?

[Y] [N] Sensitivity to Hot & Cold

[Y] [N] Problems when you chew

[Y] [N] Food Catching between teeth

[Y] [N] Clenching or Grinding your teeth

[Y] [N] Easily gag

[Y] [N] Do you feel your teeth fit together well

[Y] [N] Stiff neck/throat muscles

[Y] [N] Do you smoke or chew tobacco?

[Y] [N] Did you ever wear braces?

Does having dental treatment make you afraid or nervous? [Y] [N] If yes, what specific things bother you?_____

_____

Do you snore or even been told you snore? [Y] [N] Have you ever been diagnosed with sleep apnea? [Y] [N]

Have you ever been treated for sleep apnea? If yes, please explain_____

If you could change anything about your smile which of the following would you want? (mark all that apply)

[Y] [N] Whiter

[Y] [N] Replace missing teeth

[Y] [N] Remove stains/spots on teeth

[Y] [N] Straighter

[Y] [N] Close Space or spaces

[Y] [N] Replace old crowns

[Y] [N] Less Gum showing

[Y] [N] Replace Chipped teeth

[Y] [N] Remove silver filling(s)

[Y] [N] Replace old plastic filling(s)

[Y] [N] Reshape/resize my teeth

Please circle the following which are important to you when making your dental health decision?

Convenience	Appearance	Comfort	Quality of care
Finances	Time	Fear or Anxiety	Detailed treatment explanations
What insurance covers	Health	Relationship with Dental Team	Technology

Alpine Family Dental

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

☐ Pregnant/Trying to get pregnant? ☐ Nursing?

☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Sulfa Drugs

☐ Other If yes, please explain: _____

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

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

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

Comments: _____

_____

_____

_____

_____

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 my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____