EB

DR. EMILY BATSON

DENTISTRY & PROSTHODONTICS

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all of your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

PATIENT INFORMATION (CONFIDENTIAL)

Name _____ Date _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Email _____ Home Phone _____ Cell Phone _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If student, Name of School/College _____ City _____ State _____ ☐ Full Time ☐ Part Time

Patient or Parent/Guardian's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

May we contact you or leave a message at either home or work numbers? ☐ Yes ☐ No

RESPONSIBLE PARTY

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Driver's License Number _____ Birthdate _____

Employer _____ Work Phone _____ SSN _____

Is this person currently a patient in our office? ☐ Yes ☐ No

INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SSN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID # _____

Address of Employer _____ City _____ State _____ Zip _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SSN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID # _____

Address of Employer _____ City _____ State _____ Zip _____

PLEASE TURN OVER ›

PATIENT MEDICAL HISTORY

Physician _____

Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness? If yes, please explain. _____	☐	☐
3. Please provide a list of all medication(s) you are taking including non-prescription medicine. _____		
4. Do you currently use or have you ever used tobacco? If so, how much daily? _____	☐	☐
5. Do you use controlled substances?	☐	☐
6. Do you use any recreational substances, including alcoholic beverages? If so, how much per week? _____	☐	☐

	Yes	No
8. Have you ever taken any medication for your bones or bone density? (ie. Actonel, Fosamax, etc?)	☐	☐
9. Are you allergic to or have you had an reactions to the following?		
Local Anesthetics (e.g. Lidocaine)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list) _____	☐	☐
10. Women only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

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

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Thyroid Problem	☐	☐	Stomach Troubles/Ulcers	☐	☐
Heart Attack	☐	☐	Heart Disease/Heart Trouble	☐	☐	Angina/Chest Pains	☐	☐
Swollen Ankles	☐	☐	Cardiac Pacemaker	☐	☐	Stroke	☐	☐
Fainting/Seizures	☐	☐	Heart Murmur/MVP	☐	☐	Hay Fever/Allergies	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Tuberculosis	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Radiation Therapy	☐	☐
Epilepsy/Convulsions	☐	☐	Cancer	☐	☐	Glaucoma	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Recent Weight Loss	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Respiratory Problems	☐	☐
Kidney Disease	☐	☐	Hepatitis/Jaundice/Liver Disease	☐	☐	Osteoporosis	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Other _____	☐	☐

PATIENT DENTAL HISTORY

Name of Previous Dentist and Location _____ Date of Last Exam _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet/sour liquids/foods?	☐	☐
4. Do you have any sores or lumps in or near your mouth?	☐	☐
5. Have you had an head, neck, or jaw injuries?	☐	☐
6. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
7. Do you have frequent headaches?	☐	☐
8. Do you clench or grind your teeth?	☐	☐
9. Do you feel pain to any of your teeth?	☐	☐
10. Have you ever had any difficult extractions in the past?	☐	☐
11. Have you ever had any prolonged bleeding following extractions?	☐	☐
12. Have you had any orthodontic treatment?	☐	☐
13. Do you wear dentures or partials?	☐	☐
If yes, date of placement _____		
14. Do you like your smile?	☐	☐

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information and have accurately answered all questions to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize Dr. Batson to release any information or 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, unless I specify otherwise. I have been made aware of the privacy policies and have reviewed/been given the option to review a copy of the HIPAA notice. I have been given a copy of the financial policies for Dr. Emily R. Batson and I agree to be responsible for payment of all services rendered on my behalf or my dependents. In the event payment is not made when due, my account shall bear interest at 21% per annum, and I will be responsible for all collection costs and attorney fees incurred by Emily R Batson DDS, PC.

Signature of Patient (or parent of minor) _____ **Date** _____