Radiance Dental- Patient Information Sheet

Patient Last Name	First Name	Mi	Today's Date
-	-		
Gender	**Marital Status**	**Birth Date**	**Occupation**
Home Address	**Apt,**	**City, State**	**Zip**
	-		
Email	**Referred By**	**Home Phone**	**Work Phone**
Mobile Phone	**Pager**	**Drivers License #**	**Social Security**
Employer Name	**Address**	**City, State Zip**	**Telephone #**

Responsible Party Information

If Same As Above Check Here [ ] And Proceede To The Health History

			-
First Name - Last Name	**Mi**		**Relation To Patient**
-	-		
Gender	**Marital Status**	**Birth Date**	
Home Address	**Apt,**	**City, State**	**Zip**
E-mail	**Occupation**	**Home Phone**	**Work Phone**
Mobile Phone	**Pager**	**Drivers License #**	**Social Security #**
Employer Name	**Address**	**City, State, Zip**	**Telephone #**

Insurance Information

Primary Insurance

Insurance Name	Address	City, State Zip	Group Number
		-	
Name of Insured, Last	**First**	**Relationship to Patient-**	**Insured Birth Date**
Social Security	**Insured Address**	**City, State**	**Zip**

Secondary Insurance

Insurance Name	Address	City, State Zip	Group Number
		-	
Name of Insured, Last	**First**	**Relationship to Patient-**	**Insured Birth Date**
Social Security	**Insured Address**	**City, State**	**Zip RRA**

Dental History

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

Yes	No		Yes	No		Yes	No	
☐	☐	Broken Fillings	☐	☐	Pain in jaw when you wake up	☐	☐	Bleeding Gums
☐	☐	Bad Breath	☐	☐	Headaches when you wake up	☐	☐	Loose teeth
☐	☐	Sensitivity to cold	☐	☐	Pain in ear, joint, or side of face	☐	☐	Periodontal treatment
☐	☐	Sensitivity to hot	☐	☐	Difficulty in opening or closing	☐	☐	Bleeding gums with brushing
☐	☐	Sensitivity to sweets	☐	☐	Difficulty in chewing	☐	☐	Bleeding gums with flossing
☐	☐	Pain in your teeth	☐	☐	Frequent Headaches	☐	☐	Food collection between teeth
☐	☐	Difficult extractions	☐	☐	Grinding or clenching teeth	☐	☐	Sores or lumps in or around mouth
☐	☐	Orthodontic work	☐	☐	Clicking or popping jaw	☐	☐	Proper Brushing Instructions
☐	☐	Proper gum care	☐	☐	Head, Neck or jaw injuries	☐	☐	Proper Flossing Instructions
☐	☐	Are you dissatisfied with the alignment of your teeth?				☐	☐	Have you ever taken Phen- Fen
☐	☐	Are you dissatisfied with the color of your teeth?				☐	☐	Do you use Tobacco? *If so, how much?*
☐	☐	Are you dissatisfied with the shape of your teeth?				☐	☐	Do you use alcohol ? *If so how much ?*
☐	☐	Do you wear contact lenses?				☐	☐	Do you use drugs, or cocaine ?

Physicians Name: *Telephone*

Women

Yes	No	
☐	☐	Are you pregnant, or you think you are?
☐	☐	Are you nursing?
☐	☐	Are you taking birth control pills?

Medical History

Please check if you have or ever had any of the following conditions

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Arthritis	☐	☐	Angina	☐	☐	Stroke	☐	☐	AIDS - HIV infection
☐	☐	Asthma	☐	☐	Chest Pain	☐	☐	Anemia	☐	☐	Mitral Valve Prolapse
☐	☐	Emphysema	☐	☐	Heart Attack	☐	☐	Cancer	☐	☐	Low Blood Pressure
☐	☐	Thyroid problems	☐	☐	Heart Murmur	☐	☐	Hepatitis	☐	☐	High Blood Pressure
☐	☐	Fainting- Seizures	☐	☐	Heart Disease	☐	☐	Diabetes	☐	☐	Metal plates or Pins
☐	☐	Radiation Therapy	☐	☐	Swollen Ankles	☐	☐	Leukemia	☐	☐	Joint replacement or implant
☐	☐	Recent weight loss	☐	☐	Frequently tired	☐	☐	Glaucoma	☐	☐	Stomach trouble - ulcers
☐	☐	Hay fever- Allergies	☐	☐	Rheumatic Fever	☐	☐	Tuberculosis	☐	☐	Sexually Transmitted disease
☐	☐	Respiratory problems	☐	☐	Epilepsy- Convulsions	☐	☐	Liver disease	☐	☑	Other
☐	☐	Cardiac Pace Maker	☐	☐	Kidney Disease	☐	☐	Artificial Joints			

Check ☑ if you have allergy to :

☐ Sedatives	☐ Latex Gloves	☐ Barbiturates	☐ Penicillin or other antibiotics
☐ Sulpha	☐ Other	☐ Iodine	☐ Local Anesthetics (Novocaine)

List all the medications that you are currently taking, including non-prescription drugs

Dr. Comments

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 records of any treatment or examination rendered to my child or me during the period of such dental care to third party payers and/or health practitioners.
I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits, otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services.
I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient (or Guardian Signature)

Witness