FORD DENTAL CARE

Derek Ford, D.D.S.
Cosmetic and Family Dentistry

125 N. Rust. • Gentry, AR 72734
400 N. Walton Blvd., Suite D • Bentonville, AR 72712

Date: ____________________

PATIENT'S INFORMATION (please completely fill out first and second pages)

Patient's Full Name: ____ Name you like to be called by: ____________________
First, Middle, Last

Patient's Address: ____ Soc. Sec. #: ____________________
Street, Apt. No., City State Zip

Home Phone: (_____)________________________ Date of Birth: _____/_____/______ Marital Status: ❒Single ❒ Married

Place of Employment or School and Grade: ____ Phone: (_____)________________

Person to contact in case of emergency: ____________________ Relationship: ____________ Phone: (_____)________________

Contact's Address: ____

Whom May We Thank for Referring You? ____

PERSON RESPONSIBLE FOR ACCOUNT

Full Name: ____ Relationship to Patient (if different than above): ______________
First, Middle, Last

Full Home Address: ____ Home Phone:(_____)________________
Street, Apt. No.. City State Zip

If Less than 3 Years at above, Previous Address: ____________________________________ Date of Birth _____ /_____ /______

Marital Status: ❒ Single ❒ Married Occupation: ____

Driver's License No.: ________________________ Soc. Sec. No.: ____________________ Employer: ____________________

Work Phone: (______)________________ Years at Employer: _________ Employer's Address: ______________________________

Name of ❒ Spouse ❒ Other Parent ____________________________ Full Address: ____________________________
First, Middle, Last

or ❒ Secondary Responsible Person: ____

Date of Birth: ___________ Soc. Sec. No.: ______________ Home Phone:(_____)____________ Work Phone:(_____)____________

Employer: _______________________ Occupation (type of business): ______________________ Years at Employer: ________

RELEASE

I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist 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.

Date: __________________ **Patient or Guardian's Signature:** ____

Updated: ______________ Patient or Guardian's Signature: ____

MEDICAL AND DENTAL HISTORY (to be completed by patient)

Patient's Full Name:________________ ❒ Male ❒ Female

Date of Birth:__________ Age: (years)______ (months)______ Weight: ______ Height:______

Patient's ❒ Current ❒ Previous Dentist(s): ________________ Date of Last Dental Cleaning:______

Patient's ❒ Current ❒ Previous Physician(s):________________ Date of Last Physical Exam:______

All past medical and dental history may be important for your optimal care. Please take time to be as accurate and thorough as possible in answering the following questions (use bottom of page if necessary). THANK YOU.

A Please list your chief concerns for treatment: (# in order of priority): ________________

B What or who motivated you to seek treatment and what do you expect?________________

C Describe anything that bothers you about the appearance of your teeth, smile or face:________________

D Describe any injuries or blows to your face, jaw, mouth or teeth:________________

E List all current medications including non-prescriptions:________________

F List all drug allergies:________________

G List all previous surgeries or hospitalizations:________________

H Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (Brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine)________________

Please ✓ if "yes" to every question appropriate, and thoroughly describe (use space at bottom of page if necessary)

MEDICAL

1 High Blood Pressure______ ❒
2 Chest pains or heart attack______ ❒
3 Stroke______ ❒
4 Rheumatic Fever______ ❒
5 Shortness of breath or swollen ankles______ ❒
6 Any heart trouble, murmur, or mitral valve prolapse______ ❒
7 Prosthetic devices (heart, valve, hip, etc.)______ ❒
8 Any lung disease (T.B., emphysema, etc.)______ ❒
9 Asthma______ ❒
10 Allergies or hay fever______ ❒
11 Sinus problems______ ❒
12 Mouthbreathing or excessive snoring______ ❒
\3 Ulcers or stomach problems______ ❒
14 Diabetes______ ❒
15 Hepatitis or liver disease______ ❒
16 Kidney or bladder disease______ ❒
17 Thyroid trouble______ ❒
18 Connective tissue disease______ ❒
19 Sexually transmitted disease______ ❒
20 Arthritis or rheumatism______ ❒
21 Cancer (type, date)______ ❒
22 Serious illnesses not listed (list-type, date)______ ❒
23 Subject to prolonged bleeding or bruise easily______ ❒
24 A contact lens user______ ❒
25 Glaucoma______ ❒
26 Epilepsy, convulsions or seizures______ ❒
27 Psychiatric therapy or emotional problems______ ❒
28 Do you have HIV (AIDS)?______ ❒
29 Have you been exposed to HIV?______ ❒
30 Have you been tested for HIV?______ ❒
31 Pregnant or possible pregnant______ ❒
32 Taking birth control pills______ ❒
33 Drink coffee (cups per day)______ ❒
34 Use tobacco (types/how much)______ ❒
35 Consume alcoholic beverages______ ❒
36 Pain, popping, catching or locking in jaw joints______ ❒
37 Clench or grind your teeth______ ❒
38 Wakeup with sore jaws______ ❒
39 Frequent headaches (How many per week?____) ______ ❒
40 Dizziness, ringing or pain in ears______ ❒
41 Tenderness or stiffness in the jaw, neck or back______ ❒
42 History of TMJ (jaw joint) problems or therapy______ ❒

DENTAL

50 Treated for or told you have gum disease______ ❒
51 Treated or consulted for orthodontic therapy______ ❒
52 Had any oral surgery______ ❒
53 Dental x-rays taken in the last year______ ❒
54 Excessive fear of dental treatment______ ❒
55 Brush your teeth (how often)______ ❒
56 Floss your teeth (how often)______ ❒
57 Bad breath or unpleasant tastes in your mouth______ ❒
58 Bleeding gums______ ❒
59 Sore teeth______ ❒
60 Tooth sensitivity (hot, cold, sweets)______ ❒
61 Fever blisters or mouth ulcers______ ❒
62 Suck your thumb, finger or lip (now or in the past?)______ ❒
63 Tongue thrusting habit______ ❒
64 Gag easily______ ❒
65 Place a high priority on keeping your natural teeth______ ❒

Please expand on the above information (refer to letter or number) or add anything you feel is important: ________________

The above information is accurate and complete to the best of my knowledge:

Date:______ **Patient or Guardian's Signature:**________________ **Doctor's Signature:**________________

Updated:______ PorG'sInitials:______ Doctor's Initials: ______;______,______,______;______,______,______