SPRINGFIELD FAMILY DENTAL

636 West Republic Road, Suite 120. | Springfield, Missouri

Phone: (417)882-3200

Name_____ Preferred Name _____
Last First Middle
Address _____
City _____ State _____ Zip _____
Work Phone _____ Cell Phone _____
☐ Male ☐ Female SS# _____ Date of Birth _____
Email _____

Patient's Employer (School) _____ Occupation _____
Spouse's Name _____ SS#_____
Spouse's Date of Birth _____ Spouse's Work Phone _____
Spouse's Employer_____

Please complete this section if the patient is a minor.
Father's Name _____ SS# _____ DOB_____
Father's Employer _____ Work Phone_____
Mother's Name _____ SS#_____ DOB _____
Mother's Employer _____ Work Phone _____

Insurance Company Name_____
Group # _____ Individual Policy # _____
Relationship to Insured: ☐ Self ☐ Spouse ☐ Covered Dependent
Insured's Name _____ Insured's SS# _____
Insured's DOB _____ Insured's Employer _____

Name of person to contact in case of emergency _____
Phone Number_____ Relationship _____
Who may we thank for referring you to our office? _____

DENTAL HISTORY
Name and Location of Previous Dentist _____
Date of Last Visit _____ Reason for Last Visit_____

Do your gums bleed while brushing/ flossing? ☐ Yes ☐ No
Do you feel any pain with any of your teeth? ☐ Yes ☐ No
Have you ever experienced any of the following problems with your jaw?
- Clicking? ☐ Yes ☐ No
- Pain (joint, ear, side of face)? ☐ Yes ☐ No
- Difficulty in opening or closing? ☐ Yes ☐ No
- Difficulty in chewing? ☐ Yes ☐ No

Do you clench or grind your teeth? ☐ Yes ☐ No
Do you wear a denture or partial? ☐ Yes ☐ No
Are your teeth sensitive to temperature and/or sweets? ☐ Yes ☐ No
Have you had prolonged bleeding following extractions? ☐ Yes ☐ No

MEDICAL HISTORY

Physician _____ Office Phone _____ Date of last Exam _____

Are you under medical treatment? ☐ Yes ☐ No

Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? ☐ Yes ☐ No
If yes, please explain_____
_____
_____

Are you taking any medications including non-prescription medications? ☐ Yes ☐ No
If yes, what _____
_____
_____

Have you ever taken Fen-Phen/Redux? ☐ Yes ☐ No
Do you use tobacco? ☐ Yes ☐ No

Are you allergic to or have any reactions to the following?

Bleach	☐ Yes	☐ No
Codeine	☐ Yes	☐ No
Penicillin	☐ Yes	☐ No
Other Antibiotics	☐ Yes	☐ No
Sulfa Drugs	☐ Yes	☐ No
Iodine	☐ Yes	☐ No
Aspirin	☐ Yes	☐ No
Any Metals	☐ Yes	☐ No
Latex Rubber	☐ Yes	☐ No

Other (please list) _____

Women Only:

Are you pregnant or think you may be pregnant?	☐ Yes	☐ No
Are you nursing?	☐ Yes	☐ No
Are you taking oral contraceptives?	☐ Yes	☐ No

Do you have or have had any of the following?

Heart Disease	☐ Yes	☐ No	Stomach Trouble/ Ulcers	☐ Yes	☐ No
Cardiac Pacemaker	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Heart Mermer	☐ Yes	☐ No	Hay Fever/ Allergies	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Radiation Therapy	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Recent Weight Loss	☐ Yes	☐ No
Joint Replacement or Implant	☐ Yes	☐ No	Heart Trouble	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No
HIV	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Asthma	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No	Epilepsy/ Convulsions	☐ Yes	☐ No
High Cholesterol	☐ Yes	☐ No	Leukemia	☐ Yes	☐ No
Fainting/ Seizures	☐ Yes	☐ No	Other _____		

Consent for Treatment & Payment Policy Agreement

I certify that I have completed this form fully and completely. The above information is accurate to the best of my knowledge, and I understand that providing false information can be dangerous to my health. I grant authority to the Dentist and staff to perform the necessary exam, x-rays, and subsequent treatment needed to restore and maintain my dental health or to the health of my dependent.

I have had the opportunity to read and have a copy of this office's Notice of Privacy Practices. I authorize the Dentist to release any information including the diagnosis and records of any treatment or exam rendered to me or my dependent during the period of such dental care to third party payors and/or other health practitioners as needed for my treatment or payment thereof.

I authorize and request my insurance company to pay benefits on my behalf directly to the dentist. 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 including any collection costs, attorney fees, and court costs.

Signature _____ Date _____