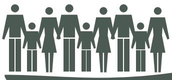

SALLY C. POWELL | DDS

We are pleased to welcome you to our practice. Please fill out this form and email it back to sally@sallypowelldds.com If you have any questions, contact us at 573-474-8566 and we would be happy to help. We look forward to working with you in maintaining your dental health.

Patient's Name: ____________________ Soc. Sec. #: ____________________
First, Middle, Last

Date of Birth: ____________ Age: ______ Sex: ❑ M ❑ F ❑ Married ❑ Single ❑ Widowed ❑ Separated ❑ Divorced

Home Address: ____________________

____
City *State* *Zip Code*

Home Phone: ____________ Cell Phone: ____________ E-Mail: ____________

Name of Employer: ____________________ Occupation: ____________________

Business Address: ____________________

Business Phone: ____________________ Business E-Mail: ____________________

Whom may we thank for referring you? ____________________

Notify in case of emergency: ____________________

Home Phone: ____________ Cell Phone: ____________ Business Phone: ____________

Insurance Information | Person responsible for account ____________________
First, Middle, Last

Relation to the patient: ____________ Soc. Sec. #: ____________ Date of Birth: ____________

Home Address *(if different from patient)*: ____________________

____
City *State* *Zip Code*

Home Phone: ____________ Cell Phone: ____________ E-Mail: ____________

Person responsible employed by: ____________________ Occupation: ____________

Business Address: ____________________ Business Phone: ____________

Insurance Company: ____________________ Phone: ____________

Contract #: ____________ Group #: ____________ Subscriber #: ____________

Name of other dependents under the plan: ____________________

Dental History

What would you like us to do today? ______

Are you in dental discomfort today? ______

Former dentist: ______

Address: ______ Phone: ______

Date of last dental care: ______ Date of last x-rays: ______

Check yes or no whether you have had problems with any of the following:

	YES	NO		YES	NO		YES	NO
Bad breath	❑	❑	Grinding or clenching teeth	❑	❑	Sensitivity to hot	❑	❑
Bleeding gums	❑	❑	Loose teeth or broken fillings	❑	❑	Sensitivity to sweets	❑	❑
Clicking or popping jaw	❑	❑	Periodontal treatment	❑	❑	Sensitivity when biting	❑	❑
Food collection between teeth	❑	❑	Sensitivity to cold	❑	❑	Sores or growths in mouth	❑	❑

How often do you brush? ______ Floss? ______

How do you feel about the appearance of your teeth? ______

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? YES ❑ NO ❑

Other information about our dental health or previous treatment: ______

Medical History

Physician's name: ______ Phone: ______ Date of last visit: ______

Have you had any serious illnesses or operations? YES ❑ NO ❑ If yes, describe: ______

Are you currently under physician care? YES ❑ NO ❑ If yes, describe: ______

Have you ever had a blood transfusion? YES ❑ NO ❑ If yes, give approximate dates: ______

Have you ever taken Fen-Phen/Redux? YES ❑ NO ❑

Women only: Are you pregnant? YES ❑ NO ❑ Nursing? YES ❑ NO ❑ Taking birth control pills? YES ❑ NO ❑

Please check all that apply:

- ❑ AIDS/HIV positive
- ❑ Anaphylaxis
- ❑ Anemia
- ❑ Arthritis, Rheumatism
- ❑ Artificial heart valves
- ❑ Artificial joint
- ❑ Asthma
- ❑ Atopic (allergy prone)
- ❑ Back problems
- ❑ Blood disease
- ❑ Cancer
- ❑ Chemical dependency
- ❑ Chemotherapy
- ❑ Circulatory problems
- ❑ Cortisone treatments
- ❑ Cough, persistent
- ❑ Cough up blood
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Fainting
- ❑ Food allergies
- ❑ Glaucoma
- ❑ Headaches
- ❑ Heart murmur
- ❑ Heart problems *describe:*
- ❑ Hemophilia/ Abnormal bleeding
- ❑ Herpes
- ❑ Hepatitis
- ❑ High blood pressure
- ❑ Jaw pain
- ❑ Kidney disease/malfunction
- ❑ Liver disease
- ❑ Material allergies (**latex**, wool, metal or chemicals)
- ❑ Mitral valve prolapse
- ❑ Nervous problems
- ❑ Pacemaker/Heart surgery
- ❑ Psychiatric care
- ❑ Rapid weight gain or loss
- ❑ Radiation treatment
- ❑ Respiratory disease
- ❑ Rheumatic/Scarlet fever
- ❑ Shingles
- ❑ Shortness of breath
- ❑ Skin rash
- ❑ Spina Bifida
- ❑ Stroke
- ❑ Surgical implant
- ❑ Swelling of feet or ankles
- ❑ Thyroid disease/malfunction
- ❑ Tobacco habit
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Ulcer/Colitis
- ❑ Venereal disease

Is the patient currently taking any medications? If yes, list all:

Does the patient have drug allergies? If yes, list all:

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form 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.

Signature ______ Date ______

Payment is due in full at time of treatment, unless prior arrangements have been approved.