ElementDental

700 W Ironwood Drive #366. Coeur d'Alene, ID 83814. 208-664-2160. www.ElementDentalCDA.com

Patient Information

Legal Name______________________________

I prefer to be called:______________________

Birthdate:____________________ Male Female

Home Address:______________________________

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Hm #__________________ Cell#__________________

Wk#__________________ Circle preferred number

E-mail______________________________

Employer:______________________________

Occupation:______________________________

Whom may we thank for referring you?__________________

Other family members seen by us?__________________

Previous/Present Dentist__________________

Last Visit Date:____________

In the event of an emergency, whom should we contact?

____

Best # to reach your contact__________________

Dental Insurance

Do you have dental insurance that we'll be billing for you?

Yes________ No________

If so, please present your insurance card to the financial coordinator

Medical History

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

- ☐ Angina / Taking heart meds
- ☐ Heart Murmur / Heart valve problem
- ☐ Pacemaker
- ☐ Taking Coumadin or Anticoagulants
- ☐ Blood Pressure problems
- ☐ Abnormal bleeding
- ☐ Botox or Dermal Fillers
- ☐ Asthma
- ☐ Joint replacements (total hip, pins, or implants)
- ☐ Are you required to take antibiotics before dental treatment?

Women:

- ☐ Taking Birth Control Pills
- ☐ Are you pregnant?
  How many weeks:______________

Are you allergic to or have you reacted adversely to any of the following:

- ☐ Local anesthetics
- ☐ Sulfa drugs
- ☐ Codeine or other narcotics
- ☐ Reaction to metals
- ☐ Penicillin or other antibiotics
- ☐ Aspirin, acetaminophen, or ibuprofen
- ☐ Latex or Rubber Dam
- ☐ Other:______________________________

Misc. Concerns:

- ☐ Diabetes
- ☐ Fainting spells
- ☐ Do you smoke or chew tobacco
- ☐ HIV / AIDS
- ☐ Cancer / Tumor
- ☐ Seizures or Epilepsy
- ☐ Hepatitis

Current List of Medications

____
____
____
____
____

Dental History

How would you describe the condition or your teeth or gums?______________________________
Are you currently in any pain or discomfort?______________________________
How often do you brush your teeth?__________________ How often do you floss your teeth?__________________
Do your gums bleed when you brush or floss?______________________________
Are you happy with your smile?______________________________
Have you experienced pain in your jaw joint?______________________________
Do you clench or grind your teeth?______________________________
Do you have sleep apnea?__________________ Do you use a CPAP?__________________

I understand that the information is correct to the best of my knowledge and it will be held in the strictest confidence. It is my responsibility to inform this office of any changes in my medical status. I authorize the release of information for insurance purposes and give consent for Dr. Fehling and her staff to treat me.

Signature of Patient or Responsible Party:______________________________ Date:______________