# RED ROSE DENTISTRY

Dr. Emily Eckdahl Dr. Terence Geary

Date: ___________

Name
_______________________________________

Address
_______________________________________

City, State, Zip__________________________

Home Phone (____)_____-__________

Date of Birth_______________

Email _________________________________

Whom May We Thank For Referring You?

_________________________________________

Employer/Occupation

__________________________________________

Business Phone (____)____-_______

Cell Phone (____)____-________

Marital Status _____________________________

Spouse's Name ____________________

Spouse's Employer/Occupation

__________________________________

Person Financially Responsible For This Account

__________________________________________

| Primary Dental Insurance Information | Secondary Dental Insurance Information |
|---|---|
| Policyholder's Name _______________________ | Policyholder's Name _______________________ |
| Policyholder's Date of Birth _________________ | Policyholder's Date of Birth _________________ |
| Insurance Company _______________________ | Insurance Company _______________________ |
| Insurance Company Telephone (___)____-_____ | Insurance Company Telephone (___)____-_____ |
| Employer ________________________________ | Employer ________________________________ |
| SSN ________-_______-_________ | SSN ________-_______-_________ |
| Member # _________ Group #______________ | Member # _________ Group #______________ |

**DENTAL HISTORY**

What is the main reason for this visit? ____________________________________________________________

Are you having any specific dental problems? _____ YES _____NO

Describe_________________________________________________________________________

Date of your last dental exam: _______________ Former Dental Office: ___________________________

How often do you brush your teeth?_______________ How often do you floss? _________________________

Are your teeth sensitive? ___YES ____NO

If Yes, Select all that apply: ___Hot ___Cold ___Sweets ___Chewing

What Teeth: ______________________________

Have you ever been told that you have periodontal (gum) disease? ___Y ___N

Have you ever been referred for or had periodontal (gum) surgery? ___Y ___N

Have you ever been told you need to pre-medicate before a dental appointment ___Y ___N

Do you feel nervous in a dental office? ___Y ___N

___________________________________*Please Complete The Back Page* ________________________________

Please check if you have had any of the following:

___ Pain In/Around Ears
___ Pain When Chewing
___ Previous Treatment for Jaw or TMJ Problems
___ Pain when opening wide
___ Difficulty Opening/Closing
___ Previous Orthodontic Treatment
___ Jaw Joint Noises
___ Jaw Muscles Tender

**Medical History**

Name of Physician ________________________________ Phone # ____________________

Address of Physician ______________________________________________________

Date of Last Physical Exam ___/____/____ ___Routine ___Illness ____________________

Have you been hospitalized in the last 5 years? ___N ___Y Reason____________________

Are you undergoing any medical treatments? ___N ___Y Describe ____________________

Are you presently taking any medication? ___N ___Y List ____________________

______________________________________________________________________

Are you allergic to any medication? ___N ___Y List ____________________

Are you or have you ever taken any bisphosphonates (Bone Density Medication)? ___N ___Y

Do you bleed abnormally after cuts or extractions? ___N ___Y

Do you smoke or use smokeless tobacco? ___N ___Y Amount ____________________

Please check if you have had any of the following:

__ AIDS/HIV+
__ Alcohol Addiction
__ Anemia
__ Ankles Swell
__ Arthritis
__ Artificial Heart Valve
__ Asthma
__ Blood Disease
__ Bruise Easily
__ Cancer
__ Chemotherapy
__ Chest Pain
__ Cold Sores
__ Diabetes
__ Drug Addiction
__ Epilepsy
__ Emphysema
__ Fainting
__ Fatigue Easily
__ Glaucoma
__ Hearing Problems
__ Heart disease
__ Heart Murmur
__ Heart surgery
__ Hepatitis A, B, C
__ Herpes I, II
__ High Blood Pressure
__ Infectious Disease
__ Intestinal Problems
__ Joint Replacements
__ Kidney Disease
__ Latex Allergy
__ Liver Disease
__ Mitral Valve Prolapse
__ Mononucleosis
__ Pacemaker
__ Psychiatric Care
__ Rheumatic Fever
__ Shortness of Breath
__ Stroke
__ T.B
__ Tumor(s)
__ Thyroid Disease
__ Ulcer(s)
__ Venereal disease

Are there any other physical, mental or emotional problems we should be aware of? ___N ___Y

Women: Are you pregnant? ____N ____Y

Are you taking birth control? ____N ____Y Type ____________________

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Patient ________________________________ Date _________
(signature)

Dentist ________________________________
(signature)

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Patient ________________________________ Date _________
(signature)