

Christopher B. Clark, D.D.S. Inc.

Coventry Woods Executive Park
28321 Kensington Lane
Perrysburg, Ohio 43551
(419) 874-3333
www.chrisclarkdds.com

Welcome

Although your dentist primarily treats the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Patient Information

First Name: _____ Last Name: _____ Middle Initial: _____
Preferred Name: _____ Address: _____
City: _____ State/Zip: _____ Employer: _____
Home Phone: _____ Work Phone: _____ Ext _____ Cellular: _____
Sex: Male Female Marital Status: Married Single Divorced Separated Widowed
Birth Date: _____ Age: _____ Soc. Sec: _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____
Address _____ Address (2): _____
City: _____ State/Zip: _____ Employer: _____
Home Phone: _____ Work Phone: _____ Ext _____ Cellular: _____
Birth Date: _____ Soc. Sec: _____
 Responsible Party is also a policy holder for Patient Primary Insurance Holder Secondary Insurance Policy Holder

Primary Insurance Information

Name of Insured _____	Your Relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Insured Soc. Sec: _____	Insured Birth Date: _____
Employer: _____	Insurance Company: _____
Address: _____	Address: _____
Address (2): _____	Address (2): _____
City, State, Zip: _____	City, State, Zip: _____

Secondary Insurance Information

Name of Insured _____	Your Relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Insured Soc. Sec: _____	Insured Birth Date: _____
Employer: _____	Insurance Company: _____
Address: _____	Address: _____
Address (2): _____	Address (2): _____
City, State, Zip: _____	City, State, Zip: _____

Names and ages of Family Members: _____
Emergency Contact: _____ Phone: _____

Dental History

Reason for visit today _____	Clicking or popping jaw _____ Yes ___ No	Previous Extractions _____ Yes ___ No
Former Dentist _____	Dry Mouth _____ Yes ___ No	If yes, when _____
City/State _____	Fingernail biting _____ Yes ___ No	Sensitivity to cold _____ Yes ___ No
Date of last dental visit _____	Food collection between teeth _____ Yes ___ No	Sensitivity to heat _____ Yes ___ No
Date of last dental X-rays _____	Grinding teeth _____ Yes ___ No	Sensitivity to sweets _____ Yes ___ No
Mark "yes" or "no" to indicate if you have any of the following:	Gums swollen or tender _____ Yes ___ No	Sensitivity when biting _____ Yes ___ No
Bad Breath _____ Yes ___ No	Jaw pain or tenderness _____ Yes ___ No	Sores/growths in mouth _____ Yes ___ No
Bleeding Gums _____ Yes ___ No	Lip or cheek biting _____ Yes ___ No	How often do you floss _____
Burning sensation on tongue _____ Yes ___ No	Loose teeth, broken teeth/fillings _____ Yes ___ No	How often do you brush _____
Chew on one side of mouth _____ Yes ___ No	Mouth breathing _____ Yes ___ No	Have you used Nitrous Oxide _____ Yes ___ No
Cigarette, pipe or cigar smoking _____ Yes ___ No	Orthodontic treatment _____ Yes ___ No	Would you like Nitrous Oxide _____ Yes ___ No
or smokeless tobacco	If yes, when _____	Are you happy with your smile _____ Yes ___ No
	Pain around ear _____ Yes ___ No	Would you like whiter teeth _____ Yes ___ No
	Periodontal treatment _____ Yes ___ No	
	If yes, when _____	

Medical History

Name of Primary Care Physician _____ Address _____ Phone _____

Date of last physical exam _____

Are you under physician's care now? ___Yes ___No If yes, please explain _____

Have you ever been hospitalized or had a major operation? ___Yes ___No If yes, please explain: _____

Have you had a serious head or neck injury? ___Yes ___No If yes, please explain: _____

Do you take OTC medications or herbal supplements? ___Yes ___No If yes, please explain: _____

Are you taking any medications? ___Yes ___No If yes, please explain: _____

Additional information so that we may give you the best possible care _____

ADD, ADHD _____ Yes ___ No	Fainting Spells/Dizziness _____ Yes ___ No	Pain in Jaw Joints _____ Yes ___ No
AIDS/HIV Positive _____ Yes ___ No	Frequent Cough _____ Yes ___ No	Parathyroid Disease _____ Yes ___ No
Alzheimer's Disease _____ Yes ___ No	Frequent Diarrhea _____ Yes ___ No	Psychiatric Care _____ Yes ___ No
Anaphylaxis _____ Yes ___ No	Frequent Headache _____ Yes ___ No	Radiation Treatment _____ Yes ___ No
Anemia _____ Yes ___ No	Genital Herpes _____ Yes ___ No	Recent Weight Loss _____ Yes ___ No
Angina _____ Yes ___ No	Glaucoma _____ Yes ___ No	Renal Dialysis _____ Yes ___ No
Arthritis/Gout _____ Yes ___ No	Hay Fever _____ Yes ___ No	Rheumatic Fever _____ Yes ___ No
Asthma _____ Yes ___ No	Heart Attack/Failure _____ Yes ___ No	Rheumatism _____ Yes ___ No
Blood Disease _____ Yes ___ No	Heart Pace Maker _____ Yes ___ No	Scarlet Fever _____ Yes ___ No
Blood Transfusion _____ Yes ___ No	Heart Trouble/Disease _____ Yes ___ No	Sexually Transmitted _____ Yes ___ No
Breathing Problem _____ Yes ___ No	Hearing Problems _____ Yes ___ No	Diseases _____ Yes ___ No
Bruise Easily _____ Yes ___ No	Hemophilia _____ Yes ___ No	Shingles _____ Yes ___ No
Cancer _____ Yes ___ No	Hepatitis A _____ Yes ___ No	Sickle Cell Disease _____ Yes ___ No
Chemotherapy _____ Yes ___ No	Hepatitis B or C _____ Yes ___ No	Sinus Trouble _____ Yes ___ No
Chest Pains _____ Yes ___ No	Herpes Type I _____ Yes ___ No	Sleep Apnea _____ Yes ___ No
Cold Sores/ Fever Blisters _____ Yes ___ No	Herpes Type II _____ Yes ___ No	Snoring Problems _____ Yes ___ No
Congenital Heart Disorder _____ Yes ___ No	High Blood Pressure _____ Yes ___ No	Spina Bifida _____ Yes ___ No
Contact Lenses _____ Yes ___ No	Hives or Rash _____ Yes ___ No	Stomach/Intestinal _____ Yes ___ No
Convulsions _____ Yes ___ No	Hypoglycemia _____ Yes ___ No	Disease _____ Yes ___ No
Cortisone Medicine _____ Yes ___ No	Hyperthyroid Disease _____ Yes ___ No	Stroke CVA or MIA _____ Yes ___ No
Drug/Alcohol Addiction _____ Yes ___ No	Hypothyroid Disease _____ Yes ___ No	Swelling of Limbs _____ Yes ___ No
Diabetes _____ Yes ___ No	Irregular Heartbeat _____ Yes ___ No	Tonsillitis _____ Yes ___ No
Depression _____ Yes ___ No	Jaundice _____ Yes ___ No	Tuberculosis _____ Yes ___ No
Easily Winded _____ Yes ___ No	Kidney Problems _____ Yes ___ No	Ulcers _____ Yes ___ No
Emphysema _____ Yes ___ No	Leukemia _____ Yes ___ No	
Epilepsy or Seizures _____ Yes ___ No	Liver Disease _____ Yes ___ No	
Excessive Bleeding _____ Yes ___ No	Low Blood Pressure _____ Yes ___ No	
Excessive Thirst _____ Yes ___ No	Lung Disease _____ Yes ___ No	
	Nervous/Anxiety Disorder _____ Yes ___ No	

Additional Medical Information

Bisphosphonates*: Do you take Yes No Have you taken Yes No Plan to take Yes No
(*drugs used to treat bone loss, osteoporosis, metabolic cancer, multiple myianoma, breast cancer, prostate cancer and paget's disease)

If yes to Bisphosphonates, do you take it **Orally** Yes No **IV** Yes No Drugs' Name _____

How long? _____ Dosage _____ Diagnosis _____

Prescribing Physician's Name: _____ Address: _____ Phone: _____

Do you have a prosthetic(artificial) Knee Hip Other Explain _____

Name of Orthopedic Surgeon _____ Phone _____ Date of Treatment _____

Do you have diabetes? Yes No If yes, treated with No Medication Oral Medication Injected Medication

Do you have any of the heart conditions? Prosthetic cardiac valve Previous infective endocarditis
 Specific congenital disease Heart transplant with valve problems

Name of Cardiologist _____ Phone _____ Date of Treatment _____

Women: Are you

Pregnant/Trying to get pregnant Yes No Taking oral contraceptives Yes No Nursing Yes No

Are you allergic to any of the following?
Aspirin___ Penicillin___ Codeine___ Nickel___ Latex___ Local Anesthetics___ NSAIDS___ Sulfa___ No Known___ Other___
Allergies

If yes please explain _____

Have you ever had any serious illness not listed above? Yes No If yes, please explain _____

Please read and initial the following

_____ I understand that I am financially responsible for all charges whether or not paid by insurance.

_____ I authorize Dr. Clark and his staff to perform all necessary dental services.

_____ I authorize Dr. Clark to release and receive information to and from my physicians and other health care providers.

_____ I authorize the use of this signature on all insurance submissions.

_____ I authorize the insurance company to pay Dr. Clark all insurance benefits otherwise payable to me for services performed.

_____ To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Date _____ Signature _____

B/P _____ P _____ Date _____

THESE UPDATES ARE FOR FUTURE USE

B/P _____ There HAS/ HAS NOT been a change in my medical history. Initial _____ Date _____

P _____ If yes, please explain _____

B/P _____ There HAS/ HAS NOT been a change in my medical history. Initial _____ Date _____

P _____ If yes, please explain _____

B/P _____ There HAS/ HAS NOT been a change in my medical history. Initial _____ Date _____

P _____ If yes, please explain _____

B/P _____ There HAS/ HAS NOT been a change in my medical history. Initial _____ Date _____

P _____ If yes, please explain _____