Schoepflin DDS

6500 SE MILE HILL DR. PORT ORCHARD 98366 (360)871-2959

Guest Information

Date _____

Name _____ M/F Birth date _____ SS # _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Business Phone _____ Email address _____

Please circle primary contact above (for making and confirming appointments.)

Spouse/Parent/Guardian Name _____

Responsible Party Driver's License # _____

Guest/Parent Employer _____ Address _____

Spouse Employer _____ Address _____

Emergency Contact Name and Number _____ Relationship_____

Whom may we thank for referring you? _____

Previous Dentist _____ Phone _____ Last Visit _____

Insurance Information

Dental Insurance Program _____ Subscriber SS # _____

Subscriber Name _____ Group Number _____

Subscriber Address (if different from above) _____

Subscriber Employer _____ Subscriber Birth date _____

Secondary Insurance Program _____ Subscriber SS # _____

Subscriber Name _____ Group Number _____

Subscriber Employer _____ Subscriber Birth date _____

Medical History

Physician _____ Office phone _____ Last Visit _____

Have you had a severe illness or been hospitalized in the last five years? **Y / N** Date _____
Reason: _____

Have you ever taken: Phen-Fen/Redux/Pondimin? **Y / N** Bisphosphonates (i.e. Fosamax)? **Y / N**

Have you been told you need pre-medication for dental visits? **Y / N** Reason: _____
Physician _____ Phone _____

Have you ever had an adverse reaction during or in conjunction with a medical or dental procedure?
Y / N _____

Please list all allergies to medications, local anesthetics, metals, latex, food, etc.

_____
_____
_____

Please list all medications you are currently taking:

Medication	*Dosage*	*Reason*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please indicate which of the following you have or have had:

____ Heart Disease
____ Angina
____ Mitral Valve Prolapse
____ Pacemaker (Yr_____)
Type _____
____ Artificial Heart Valve (yr _____)
____ Heart Murmur
____ Excessive Bleeding
____ High/Low Blood Pressure
____ Stroke (yr _____)
____ Sinus Problems
____ Frequent Cold Sores
____ Aids or HIV Infection
____ Sexually Transmitted Disease
____ Hepatitis (type _____)
____ Lung Disease/Tuberculosis
____ Arthritis
____ Seizures/Epilepsy
____ Diabetes
____ Asthma/Respiratory Problems
____ Rheumatic Fever (yr _____)
____ Cancer (type) _____ (yr_____)
____ Radiation Therapy (yr _____)
____ Chemotherapy (yr _____)
____ Tobacco usage
____ Thyroid Problems
____ Prosthetic Joints (yr _____)
____ Glaucoma

Other _____

Please list surgeon and phone number for all medical procedures above:

_____
_____

Women Only:

Are you or might you be pregnant? **Y / N** Due Date: _____

Are you nursing? Y / N Are you taking any contraceptives/hormones? **Y / N**

Dental Health

How often do you brush? _____ How often do you floss? _____

Do your gums bleed? Y / N _____

Do you notice bad breath? Y/ N _____

Are you a mouth breather? Y / N _____

Does food or dental floss get stuck between your teeth? Y / N Where? _____

Do you have frequent headaches or neck aches? Y / N _____

Location _____

Typical time of day _____

Frequency _____

Usual duration _____

Have you ever had any head, neck, or jaw injuries? Y / N _____

Do you clench or grind your teeth? Y / N _____

Does your jaw sometimes feel tired? Y / N Morning or evening?

Does your jaw get stuck (open or closed)? Y / N

Do you hear noise, clicking, or popping in your jaw joints? Y / N

Do you have any problems chewing food? Y / N

Do you frequently bite your lips, tongue, or cheek when chewing? Y / N

Are your teeth sensitive to temperature, sweet, sour, or chewing? Y / N

Do your teeth feel loose? Y / N

Do your teeth seem to be drifting? Y / N

How would you rate your smile? 1 2 3 4 5 6 7 8 9 10 Would you like to change anything?

_____

Are there any other concerns regarding your teeth you would like to discuss with Dr. Schoepflin?

_____

Authorization Signature _____

Guest and Medical History review Date _____ Initials ____ Date _____ Initials ____