DAVIS ROBERTS BOELLER RIFE

Alan F. Davis, D.M.D.
Ryan E. Roberts, D.M.D.
James N. Boeller, D.M.D.
Deanne M. Rife, D.M.D.

WELCOME

PATIENT INFORMATION

Name _____ Date _____

SS# _____ Drivers License # _____

Address _____
Street *City* *State* *Zip*

Secondary Address _____
Street *City* *State* *Zip*

Sex ☐ M ☐ F Age _____ Birthday _____

☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered for _____ years

Parent / Guardian _____

Birthdate _____ SS# _____

Occupation _____ Employer _____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____ Spouse's Employer _____

Whom may we thank for referring you? _____

INSURANCE INFORMATION

Do you currently have dental insurance? ☐ Yes ☐ No Is patient covered by any additional insurance? ☐ Yes ☐ No

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have Dental/Health insurance coverage with _____
Name of Insurance Company *ID Number*

and assign directly to Davis, Roberts, Boeller & Rife all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative / Date Please print name of Patient, Parent, Guardian or Personal Representative / Relationship to Patient

PHONE NUMBERS

Home (____) _____ Work (____) _____ Ext_____ Cell Phone (____) _____

Spouse's Work (____) _____ **E-mail Address** _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone (____) _____ Work Phone (____) _____

DENTAL HISTORY

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental x-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No
Cigarette or tobacco use	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Food collection between teeth	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Lip of cheek biting	☐ Yes	☐ No
Loose teeth or broken fillings	☐ Yes	☐ No
Mouth pain, brushing	☐ Yes	☐ No
Orthodontic treatment	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No
Sensitivity to cold	☐ Yes	☐ No
Sensitivity to heat	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No
Sensitivity when biting	☐ Yes	☐ No
Sores or growths in mouth	☐ Yes	☐ No
Are you happy with the appearance of your teeth?	☐ Yes	☐ No

If not,why? _____

_____

How often do you floss? _____

How often do you brush? _____

HEALTH HISTORY

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? ☐ Yes ☐ No

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ☐ Yes ☐ No

Date Treatment began: _____

HEALTH HISTORY

Physician's Name _____ **Date of last visit** _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Skin Rash	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No	Sleep Disorders/Apnea	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Hepatitis Type _____	☐ Yes	☐ No	CPAP Machine	☐ Yes	☐ No
Date _____			Herpes	☐ Yes	☐ No	Excessive daytime sleepiness	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Loud Snoring	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
Bleeding abnormally, with			Jaw Pain	☐ Yes	☐ No	Stent Placement	☐ Yes	☐ No
extractions or surgery	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Swollen Feet or Ankles	☐ Yes	☐ No
Cancer / Type _____	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No	Osteopenia	☐ Yes	☐ No	Tumor or growth on head		
Cortisone Treatments	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	or neck	☐ Yes	☐ No
Cough, persistant or bloody	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No	Wear Contact Lenses	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No	Weight loss, unexplained	☐ Yes	☐ No
Fainting or dizziness	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No			

Have you ever been asked to take an antibiotic one hour before a routine dental visit? ☐ Yes ☐ No

Women:

Are you pregnant ☐ Yes ☐ No

Taking birth control pills ☐ Yes ☐ No Due Date _____ Are you nursing? ☐ Yes ☐ No

Note any disease, condition or problem not listed above _____

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

_____ _____

_____ _____

Pharmacy Name _____ Phone (_____) _____

ALLERGIES

☐ **I am currently not aware of any allergies.**

☐ Aspirin	☐ Codeine	☐ Latex	☐ Sulfa
☐ Barbiturates (Sleeping pills)	☐ Iodine	☐ Penicillin	☐ Other _____

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____ 's dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any complications.
4. I understand that I can view or request a copy of the Notice of Privacy Practices at Davis, Roberts, Boeller & Rife. A copy is available upon request at the reception desk.

PATIENT or Legal Guardian _____ Date: _____

HISTORY REVIEW

Doctor's Signature _____ Date _____