The benefits of a happy, healthy smile are immeasurable. Our goal is to help you reach and maintain optimum dental health. Please fill out this confidential form completely. The better we communicate, the better we can care for you. Thank you.

ABOUT YOU

Today's Date: _____

PATIENTS NAME: _____

Preferred name: _____

□ Male □ Female

□ Single □ Married □ Divorced □ Widowed □ Separated

Date of Birth: _____/_____/_____ Age: _____

SS#: _____-_____-_____

HOME ADDRESS: _____

City _____ State _____ Zip _____

TELEPHONE NUMBERS:

Hm#: _____ Cell#: _____

WK#: _____ Other: _____

Email: _____

Preferred Contact #: □ Home □ Work □ Cell □ Other

EMPLOYER: _____

Employer's Address: _____

City _____ State _____ Zip _____

Occupation: _____ How Long: _____

SPOUSE INFORMATION

Name: _____

Employer: _____

Wk#: _____

SS#: _____-_____-_____

Date of Birth: _____/_____/_____ Age: _____

ACCOUNT INFORMATION

Person Responsible for account

Name: _____

Work#: _____ Hm#: _____

Address: _____

City _____ State _____ Zip _____

PRIMARY DENTAL INSURANCE

Insurance Company: _____

Insurance Address: _____

City _____ State _____ Zip _____

Insurance Phone #: _____

Group #: _____

Insured's Name: _____

Insured's Date of Birth: _____/_____/_____

Insured's ID #: _____

Insured's Employer: _____

Address: _____

City _____ State _____ Zip _____

SECONDARY DENTAL INSURANCE

Insurance Company: _____

Insurance Address: _____

City _____ State _____ Zip _____

Insurance Phone #: _____

Group #: _____

Insured's Name: _____

Insured's Date of Birth: _____/_____/_____

Insured's ID #: _____

Insured's Employer: _____

Address: _____

City _____ State _____ Zip _____

GETTING TO KNOW YOU

Whom may we thank for referring you?: _____

Other family members seen by us?: _____

Previous dentist: _____

Emergency Contact Name: _____

Phone Number: _____

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize Dr. Daniel S. Slaybaugh to provide information to my insurance company concerning my care. I further hereby assign all payments for dental services rendered to me, or my dependents, by the above insurance company to Dr. Daniel S. Slaybaugh. I understand that I am fully responsible for any portion of those services not covered by my insurance benefits.

Date: _____ Signature of Authorized Person: _____

Patient's Name: _____ **Date:** _____

I understand that it is my responsibility to disclose and update Dr. Slaybaugh of any changes in my medical history or medications taken prior to each appointment. I understand that Dr. Slaybaugh may not be able to treat my chief complaint due to my medical history. I understand that Dr. Slaybaugh will not be held liable for my failure to do above. I confirm that the below medications and information regarding how the medications are being taken is correct and will inform Dr. Slaybaugh of changes in my medical history and medications.

Patient or Legal Guardian's Initials _____

I. CHECK APPROPRIATE ANSWER (Leave blank if you do not understand)

1. Is your general health good? ☐Y ☐N
2. Has there been a change in your health within the last year? ☐Y ☐N
   If yes, what? _____
3. Have you been hospitalized or had a serious illness in the past year? ☐Y ☐N
   If yes, why? _____
4. Are you being treated by a physician now? ☐Y ☐N
   If yes, for what? _____
   Date of last physical exam: _____ Date of last dental exam if performed in another dental office: _____
   Physicians Name: _____ Physicians Phone # _____
5. Do you feel very nervous about having dental treatment? ☐Y ☐N
6. Have you ever had a bad experience in the dental office? ☐Y ☐N
7. Are you in pain now? ☐Y ☐N

II. HAVE YOU EXPERIENCED:

1. Chest pain (Angina)? ☐Y ☐N
2. Swollen ankles? ☐Y ☐N
3. Shortness of breath? ☐Y ☐N
4. Recent weight loss or gain, fever, night sweats? ☐Y ☐N
5. Persistent cough, coughing up blood? ☐Y ☐N
6. Bleeding problems, bruising easily? ☐Y ☐N
7. Sinus problems? ☐Y ☐N
8. Difficulty swallowing? ☐Y ☐N
9. Diarrhea, constipation, blood in stools? ☐Y ☐N
10. Frequent vomiting? ☐Y ☐N
11. Difficulty urinating, blood in urine? ☐Y ☐N
12. Dizziness? ☐Y ☐N
13. Ringing in ears? ☐Y ☐N
14. Headaches? ☐Y ☐N
15. Fainting spells? ☐Y ☐N
16. Blurred vision? ☐Y ☐N
17. Seizures? ☐Y ☐N
18. Excessive thirst? ☐Y ☐N
19. Frequent urination? ☐Y ☐N
20. Dry mouth? ☐Y ☐N
21. Jaundice? ☐Y ☐N
22. Joint pain, stiffness? ☐Y ☐N

III. DO YOU HAVE OR HAVE YOU HAD:

1. Heart disease, heart defects, artificial heart valve? ☐Y ☐N
2. Heart attack? ☐Y ☐N
   If yes, when? _____
3. Heart Murmur? ☐Y ☐N
4. Congestive heart failure? ☐Y ☐N
5. Rheumatic fever? ☐Y ☐N
6. Stroke, hardening of arteries? ☐Y ☐N
   If yes, when? _____
7. High blood pressure? ☐Y ☐N
   If yes, when were you diagnosed? _____
   What is your usual reading? _____
   How often do you see your doctor for checkup? _____
8. Asthma, Tuberculosis, Emphysema, COPD? ☐Y ☐N
   How often do you see your physician? _____
9. Sleep apnea? ☐Y ☐N
10. Hepatitis, other liver disease? ☐Y ☐N
11. Stomach problems, ulcers? ☐Y ☐N
12. Family history of diabetes, heart problems? ☐Y ☐N
13. HIV/AIDS? ☐Y ☐N
14. Tumors, cancers? ☐Y ☐N
    If yes, what type? _____ when? _____
    Treating Doctor/Hospital _____
    Are you currently undergoing chemotherapy? ☐Y ☐N
    Date last chemotherapy taken? _____
    Did you have radiation in the area of the head/neck? ☐Y ☐N
15. Arthritis, rheumatism? ☐Y ☐N
16. Eye disease? ☐Y ☐N
17. Skin disease? ☐Y ☐N
18. Anemia? ☐Y ☐N
19. Hemophilia? ☐Y ☐N
20. VD (syphilis or gonorrhea)? ☐Y ☐N
    Herpes? ☐Y ☐N
21. Sickle cell disease? ☐Y ☐N
22. Kidney, bladder disease? ☐Y ☐N
23. Thyroid, adrenal disease? ☐Y ☐N
24. Diabetes? ☐Y ☐N
    If yes, What type? _____
    Are you controlled? _____
    Sugar level when tested? _____
    How often do you check levels? _____

IV. DO YOU HAVE OR HAVE YOU HAD:

1. Psychiatric Care? ..... Y☐ N☐
2. Radiation treatment? ..... Y☐ N☐
3. Chemotherapy? ..... Y☐ N☐
4. Hospitalization? ..... Y☐ N☐
5. Blood transfusions? ..... Y☐ N☐
6. Surgeries? ..... Y☐ N☐
7. Pacemaker? ..... Y☐ N☐
8. Contact lenses? ..... Y☐ N☐
9. Artificial joints? ..... Y☐ N☐

If yes, what joints? _____

When? _____

Were you instructed to take pre-medications?. . Y☐ N☐

V. ARE YOU TAKING:

1. Recreational drugs? ..... Y☐ N☐
2. Drugs medications, over the counter medicines (including Aspirin) or natural remedies?. Y☐ N☐
3. Tobacco in any form? ..... Y☐ N☐
4. Alcohol? ..... Y☐ N☐
5. Blood thinners? ..... Y☐ N☐

Coumadin/Warfarin, Heparin/Lovenox, Plavix, Xarelto,

Aspirin? ..... Y☐ N☐

If yes, how long on medication? _____

Why on medication? _____

Last time you have seen prescribing Doctor? _____

Please list all medications or natural remedies below in section VIII.

VI. WOMEN ONLY:

1. Are you or could you be pregnant or nursing?.... Y☐ N☐ 2.Taking birth control? ..... Y☐ N☐

VII. ALL PATIENTS:

1. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are tired? ..... Y☐ N☐
2. Do you or have you had any other disease or medical problem NOT listed on this form? ..... Y☐ N☐

If so, please explain: _____

_____

_____

VIII. IF YOU ARE TAKING MEDICATIONS, PLEASE LIST:

Name of Medication	Dose	Directions	How Long on Medication

1. Are you allergic or have you reacted adversely to any of the following substances: (Please check if Y)..... Y☐ N☐

☐ Local Anesthetic ☐ Aspirin or Ibuprofen ☐ Valium ☐ Penicillin/Amoxicillin ☐ Scopolamine

☐ Codeine or other narcotics ☐ Latex ☐ Iodine ☐ Other Antibiotics

2. Are you aware of being allergic to any other medication or substance not listed? ..... Y☐ N☐
3. PLEASE DESCRIBE YOUR REACTION TO THE ALLERGEN: _____

_____

CONSENT:

I certify the above information is true to the best of my knowledge. The undersigned hereby authorize Dr. Slaybaugh to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Slaybaugh to make a thorough diagnosis of the patient's dental needs.

PATIENT: _____ **DATE**: _____ **DOCTOR/WITNESS**: _____

Parent or Responsible Party: _____ **Relationship to Patient**: _____

Name _____

Please check "Yes" or "No" as applicable to all below:

Have you had complications from past dental treatment?	Y☐ N☐
Have you had trouble getting numb?	Y☐ N☐
Have you had/have braces, orthodontic treatment?	Y☐ N☐
Do you experience dry mouth?	Y☐ N☐
Are any teeth sensitive to hot, cold, biting, sweets or do you avoid brushing any part of your mouth?	Y☐ N☐
Does food get trapped between any teeth?	Y☐ N☐
Have you ever whitened or bleached your teeth?	Y☐ N☐
Have you experienced popping and/or clicking of your jaw joint?	Y☐ N☐
Doyou have difficulty chewing?	Y☐ N☐
Doyou clench or grind your teeth?	Y☐ N☐
Doyou wear or have worn a bite appliance?	Y☐ N☐
Do your gums bleed when brushing or flossing?	Y☐ N☐
Have you been treated for gum disease or told you have lost bone around your teeth?	Y☐ N☐
Have you noticed an unpleasant taste or odor in your mouth?	Y☐ N☐
Have you experienced gum recession?	Y☐ N☐
Have any teeth become loose on their own (without injury)?	Y☐ N☐
Have you experienced a burning sensation in your mouth?	Y☐ N☐
Doyou snore or wake up frequently during the night?	Y☐ N☐

If any of the checked boxes need further explanation, please describe:

_____

_____

_____

_____

_____