FRISBIE FAMILY DENTISTRY
Kent Frisbie, D.D.S.

Med. Alert______Pre-Med______Allergies_______ DATE:____________

PATIENT INFORMATION

Name____Birthdate_________________________________

Telephone______________________Work #___________________ Cell phone #___________________________

Address_____________________________City___________State________ Zip Code______________________

Employer___________________________________ Spouse's Name _____________________________________

Soc. Sec. Number__________________________ E-mail Address ____

Emergency Contact _______________________ Relationship_____________ Emergency Phone _____________________

If patient is a minor, who is legally responsible? Please list the name, complete address and phone number:

____

Whom may we thank for referring you?____

INSURANCE INFORMATION

Name of primary insurance__________________________ Group#__________ Employer___________________________

Insurance Address______________________________________Phone #____________________________________

Employee/Subscriber_____________________________SSN#______________ Birthdate________________________

Relationship to Employee______________Full-time student?______Name of School__________ _____City____________________

Is the patient covered by a secondary dental plan? _____ Name of Carrier________________________Group # _____________________

Insurance Address______________________________________Phone #____________________________________

Employee/Subscriber ____________________________ SSN# ______________ Birthdate _______________________

Employer ____Relationship to employee __________________________

A service charge of 1-1/2% per month (18% annual rate) will be applied to balances over 90 days, $1.00 minimum charge.

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to the insurance claim. If the patient is a minor, permission is granted for dental treatment, as deemed necessary to be performed in our office or until written notice is given discounting this permission.

Signature required____________________________________ Date____________________________

I hereby authorize payment of the dental benefits otherwise payable to me directly to Dr. Kent Frisbie.

Signature required____________________________________ Date____________________________

Your answers are for our records only and will be kept confidential in accordance with applicable laws.

What is your chief complaint?____

Are you happy with your teeth and their apperance?_________If not, what would you like to see different?________________________________

Date of your last dental visit:______________________________Date of last dental x-rays:____

Yes	No	Don't Know		Yes	No	Don't Know	
☐	☐	☐	Do your gums bleed when you brush?	☐	☐	☐	Have you ever had orthodontic treatment?
☐	☐	☐	Are your teeth sensitive to cold/hot, sweets or pressure?	☐	☐	☐	Have you ever had periodontal treatment?
☐	☐	☐	Do you have headaches, earaches, or neck pain?	☐	☐	☐	Do you wear removable dental appliances?
☐	☐	☐	Have you ever had a bad reaction to dental anesthetic?	☐	☐	☐	Have you ever been told you grind your teeth?
☐	☐	☐	Does food catch between your teeth?	☐	☐	☐	Are you aware of your jaw clicking or popping?
☐	☐	☐	Have your teeth ever been bleached?	☐	☐	☐	Do you have dental implants?

Medical Information

Physician name________________________________Date of last visit_________________________Condition treated______________________

Yes	No	Don't Know	
☐	☐	☐	Are you taking any medications including non-prescription medications? If so what are you taking?__________________________
☐	☐	☐	Are you in good health? If any changes in your general health within the past year please describe:__________________________
☐	☐	☐	Are you taking, or have you taken any diet drugs? (Pondimin, Redux, or Phen-fen)
☐	☐	☐	Do you use tobacco (smoking, snuff, chew)? Frequency and amount:____
☐	☐	☐	Do you wear contact lenses?
☐	☐	☐	Are you pregnant? Due date:_______________Nursing?________________Birth Control Pills?__________________________
☐	☐	☐	Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? If so, when_________________________________

Allergies:

Yes	No	Don't Know		Yes	No	Don't Know	
☐	☐	☐	Local anesthetics	☐	☐	☐	Latex
☐	☐	☐	Aspirin	☐	☐	☐	Iodine
☐	☐	☐	Penicillin or other antibiotics_______________________	☐	☐	☐	Hay Fever / Seasonal
☐	☐	☐	Barbiturates, sedatives or sleeping pills______________	☐	☐	☐	Animals
☐	☐	☐	Sulfa drugs	☐	☐	☐	Codeine or other narcotics_____________

To yes responses, specify type and reaction____

Please **(x)** if you have or had any of the following diseases or problems.

Yes	No	Don't Know		Yes	No	Don't Know		Yes	No	Don't Know	
☐	☐	☐	Abnormal Bleeding	☐	☐	☐	Chronic pain	☐	☐	☐	Neurological disorders
☐	☐	☐	AIDS or HIV infection	☐	☐	☐	Persistent diarrhea	If yes, specify:			
☐	☐	☐	Anemia	☐	☐	☐	Disease, drug or radiation-	☐	☐	☐	Osteoporosis
☐	☐	☐	Arthritis				Induced immunosurpression	☐	☐	☐	Persistent swollen neck glands
☐	☐	☐	Rheumatoid arthritis	☐	☐	☐	Diabetes -specify type	☐	☐	☐	Respiratory problems
☐	☐	☐	Asthma	○ Type I (insulin dep) ○ Type II				○ Emphysema ○ Bronchitis, etc.			
☐	☐	☐	Blood transfusion	☐	☐	☐	Dry Mouth	☐	☐	☐	Severe headaches
			Date:	☐	☐	☐	Eating disorder	☐	☐	☐	Severe or rapid weight loss
☐	☐	☐	Cancer / chemo / radiation	If yes, specify type:				☐	☐	☐	Sexually transmitted disease
☐	☐	☐	Cardiovascular disease	☐	☐	☐	Epilepsy	☐	☐	☐	Sinus trouble
			○ Angina	☐	☐	☐	Fainting spells or seizures	☐	☐	☐	Sleep disorder
			○ Arteriosclerosis	☐	☐	☐	G.E. Reflux	☐	☐	☐	Sores or ulcers in the mouth
			○ Artificial heart valves	☐	☐	☐	Glaucoma	☐	☐	☐	Stroke
			Date:	☐	☐	☐	Hemophilia	☐	☐	☐	Systemic lupus erythematosus
			○ Coronary insufficiency	☐	☐	☐	Hepatitis/jaundice/liver disease	☐	☐	☐	Thyroid problems
			○ Coronary occlusion	☐	☐	☐	Recurrent infections	☐	☐	☐	Tuberculosis
			○ Damaged heart valves	If yes, specify type:				☐	☐	☐	Ulcers
			○ Heart Attack	☐	☐	☐	Kidney problems	☐	☐	☐	Excessive Urination
			○ Heart Murmur	☐	☐	☐	Low blood pressure	☐	☐	☐	Do you have any disease
			○ High blood pressure	☐	☐	☐	Mental health disorders	Specify:			
			○ Inborn heart defects	If yes, specify type:							
			○ Mitral valve prolapse	☐	☐	☐	Malnutrition				
			○ Pacemaker	☐	☐	☐	Migranes				
			○ Rheumatic heart disease	☐	☐	☐	Night sweats				
☐	☐	☐	Chest pain upon exertion								

I certify that I have read and understand the above. I acknowledge that my questions, if any, have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. ____

Signature of Patient / Legal Guardian Date