Stubbs Dental

David Stubbs, DDS

Date: ____________________

Name: ______________________________________ Date of Birth: ________________________

Hm Phone: ___________________ Wk Phone: ________________ Cell Phone: _________________

SSN: ______________________ E-mail: ____

Home Address: _____________________________________ City: ____________ State: ______

Spouse's Name: ______________________ Employer: _____________ Wk Phone: ____________

Insurance Information: Ins. Co. _________________________ Subscriber Name: ________________

Policy ID #: ____ Subscriber DOB: ________________

Nearest Relative not living with you: ____________________________ Hm Phone: _____________

Physician: ____, Phone: ______________________

I will be paying today by Cash: ________, Check: ________, Credit Card: _______

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status of the above information.

__________________________________   __________________________________

Signature   Date

__________________________________   __________________________________

Parent (if Minor)   Date

PATIENT MEDICAL HISTORY

Physician ________________________ Office Phone ______________ Date of last exam ____________

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized in the past 5 yrs?	☐	☐
If yes, Please Explain ______________		
3. Are you taking any medications?	☐	☐
What medications: ________________		
(Include those not prescribed by your Dr.) _____		
4. Have you ever taken Fosamax, Actonel, Boniva?	☐	☐
5. Do you use Tobacco?	☐	☐
6. Do you use controlled substances?	☐	☐
7. Do you wear contact lenses?	☐	☐
8. Do you have a persistent cough or throat clearing not associated with a known illness (more than three weeks)?	☐	☐

9. Are you allergic to or have any reactions to the following?	Yes	No
Medication's	☐	☐
Local Anesthesia (e.g. Novocain)	☐	☐
Penicillin or any other antibiotics	☐	☐
Sulfa	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex (Rubber)	☐	☐
Other (please list) ______________________		
10. **WOMEN ONLY**		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

11. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High blood pressure	☐	☐	Heart Disease	☐	☐	Chest pains	☐	☐
Heart attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily winded	☐	☐
Rheumatic fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen ankles	☐	☐	Angina	☐	☐	Hay fever/allergies	☐	☐
Fainting/seizures	☐	☐	frequently tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation therapy	☐	☐
Low blood pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy/convulsions	☐	☐	Cancer	☐	☐	Recent weight loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver disease	☐	☐
Diabetes	☐	☐	Joint replacement or implant	☐	☐	Heart Trouble	☐	☐
Kidney disease	☐	☐	Hepatitis/Jaundice	☐	☐	Respiratory problems	☐	☐
AIDS of HIV infection	☐	☐	Sexually transmitted disease	☐	☐	Mitral valve prolapsed	☐	☐
Thyroid problems	☐	☐	Stomach problems/Ulcers	☐	☐	Other (Explain) ______________		

PATIENT DENTAL HISTORY

Name of your prior Dentist______________________________ Date of last exam ________________

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are you teeth sensitive to sweet or sour?	☐	☐
4. Do you feel pain in any of your teeth?	☐	☐
5. Do you have any sores or lumps in your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems with your jaw?		
- Clicking	☐	☐
- Pain (joint, ear side of face)	☐	☐
- Difficulty in opening or closing	☐	☐
- Difficulty in chewing	☐	☐
8. Do you have frequent headaches?	☐	☐
9. Do you clinch or grind your teeth?	☐	☐

	Yes	No
10. Do you bite your lips or cheeks often?	☐	☐
11. Have you ever had any difficult extractions?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, Date of Placement ____________		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your Smile?	☐	☐