115 S Main St
Homedale, ID 83628
(208)-337-4383

Owyhee Family Dental

"Making Your Smile Great Again!"

Name:_____ Preferred Name:_____

Mailing Address:_____ City_____ State_____ Zip_____

Home Phone:_____ Work Phone:_____

Cell Phone:_____ Email:_____

How would you prefer to be contacted? ☐ Home ☐ Cell ☐ Work ☐ Text ☐ Email

Social Security Number:_____ Date of Birth:_____

Employer:_____ Occupation:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Gender: ☐ Male ☐ Female

Any other family members seen by us?_____

Spouse's Name:_____ Date of Birth:_____

Spouse's Employer:_____ Occupation:_____

Emergency Contact:_____ Phone:_____ Relationship:_____

If patient is a minor, please give the parent or guardian's name:_____

Who is responsible for this account?_____

How did you hear about our office? ☐ Patient Referral (Patient's Name)_____

☐ Other_____

INSURANCE INFORMATION

Do you have Dental Insurance? ☐ Yes ☐ No ☐ Self Pay

Subscribers Name:_____ Relationship to Patient:_____

Subscriber ID:_____ Subscriber Birth Date:_____

Insurance Co:_____ Group #:_____

ASSIGNMENT AND RELEASE

I certify that I (or my Dependent) have insurance coverage as indicated and assign directly to this office all insurance benefits 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 doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature:_____ Date:_____

Have you ever had any of the following diseases or medical problems?

Abnormal Bleeding	Y N	Frequent Headaches	Y N	Mitral Valve Prolapse	Y N
Alcohol/Drug Abuse	Y N	Glaucoma	Y N	Pacemaker	Y N
Anemia	Y N	Hay Fever	Y N	Psychiatric Problems	Y N
Arthritis	Y N	Heart Attack	Y N	Radiation Treatment	Y N
Artificial Bones/Joints/Valves	Y N	Heart Murmur	Y N	Rheumatic/Scarlet Fever	Y N
Asthma	Y N	Heart Surgery	Y N	Seizures	Y N
Blood Transfusion	Y N	Hemophilia	Y N	Shingles	Y N
Cancer/Chemotherapy	Y N	Hepatitis	Y N	Sickle Cell Disease	Y N
Colitis	Y N	Herpes/Fever Blisters	Y N	Sinus Problems	Y N
Congenital Heart Defect	Y N	High Blood Pressure	Y N	Stroke	Y N
Diabetes	Y N	HIV+/AIDS	Y N	Thyroid Problems	Y N
Difficulty Breathing	Y N	Hospitalized for any reason	Y N	Tuberculosis (TB)	Y N
Emphysema	Y N	Kidney Problems	Y N	Ulcers	Y N
Epilepsy	Y N	Liver Disease	Y N	Venereal Disease	Y N
Fainting Spells	Y N	Low Blood Pressure	Y N		

Medical History (continued)

Your current physical health is (please circle one): Good / Fair / Poor

Are you currently under the care of a physician? Yes / No Please explain: _____

_____

Are you taking any prescription/over-the-counter drugs? Yes / No

Please list each one: _____

For women: Are you taking birth control pills? Yes / No

Are you pregnant? Yes / No Are you nursing? Yes / No

Please list any medical condition(s) that you have ever had: _____

_____

Are you allergic to any of the following? Aspirin, Codeine, Dental Anesthetics, Erythromycin, Jewelry/Metals, Latex, Penicillin, Tetracycline, other: _____

Dental History

Why have you come to the dentist today? _____

Has your doctor told you that you require antibiotics before dental treatment? Yes / No

Have you ever had a serious/difficult problem associated with any previous dental work? Yes / No

Do you or have you ever experienced pain/discomfort in you jaw joint (TMJ/TMD)? Yes / No

Your current dental health is: Good / Fair / Poor Are you currently in pain? Yes / No

Do you like your smile? Yes / No Do your gums ever bleed? Yes / No

How many times a day do you floss? _____ How many times a day do you brush? _____

Type of bristles? Hard / Medium / Soft

I certify that the above information is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my (or patient's) health. I will not hold my dentist or any member of his Dental Team responsible for errors or omissions that I have made in completion of this form. It is my responsibility to notify my Dentist of any changes in the above medical status.

Patient or Responsible Party Signature: _____ **Date:** _____

I certify that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

Patient or Responsible Party Signature: _____ Date: _____