SUMMIT VIEW
BIOLOGICAL DENTISTRY & WELLNESS

3070 Rasmussen Rd, Ste 290, Park City, UT 84098
435-649-2078

Patient Name: _____ Preferred Name: _____

Birth Date: _____ Age: _____ SSN: _____ Sex: M F

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone:_____ Cell Phone: _____ Text Messages: Yes No

Email Address: _____

Marital Status (circle one): Married Single Widowed Divorced Child

Emergency contact person: _____ Phone: _____

Relationship to Patient: _____

Who may we thank for referring you? _____

Dental Insurance Information:

Please note, insurance is considered a method of **reimbursing the patient fees paid to the provider and is **not** a substitute for payment. **As a courtesy,** we will file your insurance claims, however, all charges are your responsibility on the date services are rendered.

Primary Insurance: _____ (Please give receptionist your card to copy)

Policy Holder Name: _____ Birth Date: _____ SSN: _____

Relationship to patient: _____ Employer: _____

Insurance Company Name:_____ Phone number:_____

Policy ID#: _____ Group#: _____

Claims Address: _____
_____
_____

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking could have an important inter-relationship with the care you will receive.

Are you under physicians care now? No Yes Explain: _____

Have you ever been hospitalized or had a major operation? No Yes _____

Have you ever had a serious head or neck injury? No Yes _____

Do you take or have you taken (circle): Bisphosphonates, Fosamax, Aredia, Zometa, Ortonal or Boniva?

Are you on a special diet? _____

Do you use controlled substances? No Yes Please list: _____

Do you use Tobacco? No Yes Please list: _____

Are you taking any medications, pills or drugs? Please list: _____

_____

Do you have any allergies? No Yes Please list: _____

Do you have or have you had any of the following conditions that may require medication:

☐ Aids/HIV	☐ Excessive Bleeding	☐ Parathyroid Disease
☐ Alzheimer's	☐ Excessive Thirst	☐ Psychiatric Care
☐ Anaphylaxis	☐ Fainting Spells/Dizziness	☐ Radiation Treatment
☐ Anemia	☐ Frequent Cough	☐ Recent Weight Loss
☐ Angina	☐ Frequent Diarrhea	☐ Renal Dialysis
☐ Arthritis/Gout	☐ Frequent Headaches	☐ Rheumatic Fever
☐ Artificial Heart Valve	☐ Genital Herpes	☐ Rheumatism
☐ Artificial Joint	☐ Glaucoma	☐ Scarlet Fever
☐ Asthma	☐ Hay Fever	☐ Shingles
☐ Blood Disease	☐ Heart Attack/Failure	☐ Sickle Cell Disease
☐ Breathing Problems	☐ Heart Disease	☐ Sinus Trouble
☐ Bruise Easily	☐ Heart Murmur	☐ Spina Bifida
☐ Cancer	☐ Hemophilia	☐ Stomach/Intestine Disease
☐ Chemotherapy	☐ Hepatitis A, B or C	☐ Stroke

☐ Chest Pains	☐ Herpes	☐ Swelling of Limbs
☐ Cold Sores	☐ High Blood Pressure	☐ Thyroid Disease
☐ Congenital Heart Disorder	☐ Hives or Rash	☐ Tonsillitis
☐ Convulsions	☐ Hypoglycemia	☐ Tuberculosis
☐ Cortisone Medicine	☐ Irregular Heartbeat	☐ Tumors or Growths
☐ Diabetes	☐ Kidney Problems	☐ Ulcers
☐ Drug Addiction	☐ Low Blood Pressure	☐ Venereal Disease
☐ Emphysema	☐ Lung Disease	☐ Yellow Jaundice
☐ Epilepsy Pain in Jaw Joints	☐ Mitral Valve Prolapse	

Have you ever had any serious illness not listed above? Yes No _____

_____

_____

_____

Dental Health History

Dental History Date of last Dental Exam? _____

Are you having any dental discomfort at this time? Yes No
Location: (top, bottom, left, right, front) _____

Do you feel nervous about having dental treatment? Yes No

Are your teeth sensitive to hot or cold or sweets? Yes No

Are you interested in Whitening your smile? ..... Yes No

How often do you brush your teeth? _____ Floss?_____

Do your gums bleed while brushing or flossing? Yes No

Do you get frequent fever blisters, mouth ulcers or sores on your lips or in your mouth? Yes No

Have you ever had burning of the tongue or cracking of the corners of your mouth? Yes No

Do you chew/smoke tobacco in any form? Yes No

Have you had any head, neck or jaw injuries? Yes No

Do you notice popping, clicking, or soreness of the jaws or point just in front of the ears? Yes No

Do you clench or grind your teeth? Yes No

Have you ever had orthodontic treatment? Yes No If yes, when: _____

Do you wear dentures or partials? Yes No

Are you happy with your dentures? Yes No N/A

Do you have problems with your teeth or fillings breaking? Yes No

Do you have, or have you ever been told you have Pyorrhea (Periodontal Disease)? Yes No

Do you have difficulty opening your mouth widely? Yes No

Do you have an unpleasant taste or odor in your teeth/mouth? Yes No

Does food catch between your teeth? Yes No

Are you happy with your smile? Yes No

Would you like to change anything about your smile? _____

_____

Are you having any dental discomfort at this time? Yes No Explain: _____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patients) health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____

Signature of Patient, Parent or Guardian Date