Karina Spillman, DDS
A Professional Corporation

WELCOME TO OUR OFFICE

So that we might become better acquainted, please complete this form.

Today's Date _____/_____/_____ E-mail Address _____

Patient's Name Mr. Mrs. Ms. Dr. _____
(Last) (First) (Middle)

I prefer to be called _____ SS# _____/_____/_____

Birth Date _____/_____/_____ Age _____ Sex: F ☐ M ☐

Home Address _____ City _____ State _____ Zip _____

Home ( ) _____ Cell ( ) _____ Work ( )_____ Ext _____

Employer's Name _____ Occupation _____

Employer's Address _____ City _____ State_____ Zip _____

Spouse's Name _____ Birth Date _____/_____/_____ Age _____

Spouse's Employer _____ Spouse's Contact # ( ) _____

Referred by _____ Other family members seen by us _____

Person responsible for account _____ Relation _____ Phone ( ) _____

Previous / Present Dentist _____ Phone ( ) _____**Last Visit**_____

DENTAL INSURANCE INFORMATION

Primary Carrier (If applicable)

Name of Insured (Employee) _____ Relation _____

Insured's ID# _____ Insured's Date of Birth _____/_____/_____

Insurance Company Name _____Group # _____ Ins Phone ( ) _____

Insurance Company Address _____ City _____ State _____ Zip _____

Employer's Name & Address _____

Secondary Carrier (If applicable)

Name of Insured (Employee) _____ Relation _____

Insured's ID# _____ Insured's Date of Birth _____/_____/_____

Insurance Company Name _____Group # _____ Ins Phone ( ) _____

Insurance Company Address _____ City _____ State _____ Zip _____

Employer's Name & Address _____

MEDICAL HISTORY

Name of personal physician _____ Phone # ( ) _____
Are you currently under the care of a physician? Yes ☐ No ☐ Date of last visit _____/_____/_____
If yes, please explain _____
Your current physical health is **Good [ ] Fair [ ] Poor [ ]** Your current dental health is **Good [ ] Fair [ ] Poor [ ]**

Do you smoke or use tobacco in any other form? Yes [ ] No [ ]
Do you have any metal rods, pins or implants? Yes [ ] No [ ]
Are you taking any prescription, over-the-counter or herbal supplemental drugs? Yes [ ] No [ ]
Please list each one and the reason for taking it_____
_____
Have you ever taken Fosamax, or any other bisphosphonate? Yes [ ] No [ ]
Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath? Yes **[ ]** No **[ ]**
For Women: Are you using a prescribed method of birth control? Yes **[ ]** **No [ ]**
Are you pregnant? Yes **[ ]** **No [ ]** Week # _____ Are you nursing? Yes [ ] No [ ]

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

Abnormal Bleeding	Yes [ ] No [ ]	Alcohol / Drug Abuse	Yes [ ] No [ ]	Anemia	Yes [ ] No [ ]
Arthritis	Yes [ ] No [ ]	Artificial Bones/Joints/Valves	Yes [ ] No [ ]	Asthma	Yes [ ] No [ ]
Blood Transfusion	Yes [ ] No [ ]	Cancer / Chemotherapy	Yes [ ] No [ ]	Cholesterol	Yes [ ] No [ ]
Colitis	Yes [ ] No [ ]	Congenital Heart Defect	Yes [ ] No [ ]	Diabetes	Yes [ ] No [ ]
Difficulty Breathing	Yes [ ] No [ ]	Endocrine Disorders	Yes [ ] No [ ]	Emphysema	Yes [ ] No [ ]
Epilepsy	Yes [ ] No [ ]	Fainting Spells	Yes [ ] No [ ]	Frequent Headaches	Yes [ ] No [ ]
Glaucoma	Yes [ ] No [ ]	Hay Fever	Yes [ ] No [ ]	Heart Attack	Yes [ ] No [ ]
Heart Murmur	Yes [ ] No [ ]	Heart Surgery	Yes [ ] No [ ]	Hemophilia	Yes [ ] No [ ]
Hepatitis	Yes [ ] No [ ]	Herpes / Fever Blisters	Yes [ ] No [ ]	High Blood Pressure	Yes [ ] No [ ]
HIV+ / AIDS	Yes [ ] No [ ]	Hives / Rash	Yes [ ] No [ ]	Kidney Disease	Yes [ ] No [ ]
Liver Disease	Yes [ ] No [ ]	Low Blood Pressure	Yes [ ] No [ ]	Lupus	Yes [ ] No [ ]
Mitral Valve Prolapse	Yes [ ] No [ ]	Nervous / Anxious	Yes [ ] No [ ]	Osteoporosis	Yes [ ] No [ ]
Pacemaker	Yes [ ] No [ ]	Paget's Disease	Yes [ ] No [ ]	Psychiatric Treatment	Yes [ ] No [ ]
Radiation Treatment	Yes [ ] No [ ]	Rheumatic / Scarlet Fever	Yes [ ] No [ ]	Seizures	Yes [ ] No [ ]
Shingles	Yes [ ] No [ ]	Sickle Cell Disease/Traits	Yes [ ] No [ ]	Sinus Problems	Yes [ ] No [ ]
Stroke	Yes [ ] No [ ]	Thyroid Disease	Yes [ ] No [ ]	Tuberculosis (TB)	Yes [ ] No [ ]
Ulcers	Yes [ ] No [ ]	Venereal Disease	Yes [ ] No [ ]		

Please list any serious medical condition(s) or hospitalization(s) you have ever had:

_____
_____

Are you allergic to any of the following?

Aspirin	Yes [ ] No [ ]	Codeine	Yes [ ] No [ ]	Dental Anesthetics	Yes [ ] No [ ]
Erythromycin	Yes [ ] No [ ]	Latex	Yes [ ] No [ ]	Penicillin	Yes [ ] No [ ]
Tetracycline	Yes [ ] No [ ]	Other	Yes [ ] No [ ]		

Please list any other drugs / materials that you are allergic to:

_____

Karina Spillman, DDS
A Professional Corporation

DENTAL HISTORY

Why have you come to the dentist today? _____

Do you require antibiotics before dental treatment? Yes [ ] No [ ] Are you currently in pain? Yes [ ] No [ ]

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

Do you have fears about going to the dentist? Yes[ ] No [ ] Have you ever had periodontal (gum) treatment? Yes [ ] No [ ]

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

Do you like your smile? Yes [ ] No [ ] Are your teeth sensitive to heat, cold, or anything else? Yes [ ] No [ ]

How many times a week do you floss? ___ a day do you brush? ___ Type of bristles? Soft [ ] Medium [ ] Hard [ ]

Do your gums ever bleed? Yes [ ] No [ ] How long do you use a toothbrush before replacing it? _____

I, the undersigned, have given the above dental and medical information, have reviewed it and find it accurate. If there are any changes to this record, I will inform this practice. I also understand that this information will be held in the strictest confidence. I have received a copy of this office's Notice of Privacy Practices.

INSURANCE INFORMATION

A dental insurance policy is a contract between the insured and the insurance company. Our professional services are rendered and charged directly to the patient's account and the patient or person responsible for the account is responsible for payment of all fees incurred. For you convenience, we will gladly assist you in submitting insurance claims pertaining to any charge for care in our office. If you wish assistance, we ask that you provide us with a claim form from your insurance carrier on you first visit or as soon as possible. Otherwise we will assume you are submitting all claims to your insurance carrier and the fees will be due in full from you at time of service or billing.

_____ ____/____/_____ _____ ____/____/_____

Signature Date Reviewed By Date