Welcome.

COUNTRYCLUB DENTAL
FLAGSTAFF

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

ABOUT YOU:

Today's Dote: _____ / _____ / _____

Name: _____
LAST FIRST MI MR. / MRS. / MS. / DR.

I prefer to be called: _____

Email Address: _____

Birthdate: _____ / _____ / _____ Age: _____

SS#: _____ ❍ Male ❍ Female

Home Address: _____
APT / SUITE

_____
CITY STATE ZIP

Hm: (_____) _____

Cell: (_____) _____

Wk: (_____) _____ Ext: _____

DL#: _____

❍ Single ❍ Married ❍ Divorced ❍ Widowed ❍ Separated

Employer: _____

Occupation: _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____

Last Visit Date: _____ / _____ / _____

INSURANCE INFORMATION:

Primary Insurance

Insurance Co. Name: _____

Address: _____

Phone#: (_____) _____

Group# : _____

Member ID# : _____

Insured's Name: _____ Relation: _____

Birthdate: _____ / _____ / _____

Employer: _____

Employer's Phone#: (_____) _____

Secondary Insurance

Insurance Co. Name: _____

Address: _____

Phone#: (_____) _____

Group# : _____

Member ID# : _____

Insured's Name: _____ Relation: _____

Birthdate: _____ / _____ / _____

Employer: _____

Employer's Phone#: (_____) _____

Emergency Contact

Name: _____ Relation: _____

Wk#: (_____) _____

Hm#: (_____) _____

Address: _____

_____

SPOUSE INFORMATION:

His / Her Name: _____

Contact: (_____) _____ Ext: _____

Birthdate: _____ / _____ / _____

Person Responsible for Account: _____

Relation: _____ Contact#: (_____) _____

Billing Address: _____

_____

SS #: _____ or DL#: _____

MEDICAL HISTORY:

Physician's Name: _____

Phone#: (_____) _____

Date of last visit: _____ / _____ / _____

Are you currently under the care of a physician? ❍ Yes ❍ No

Please explain: _____

Do you smoke or use tobacco in any other form? ❍ Yes ❍ No

Have you had 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: _____

_____

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 any 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 medical problems?

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

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

_____

_____

Are you allergic to any of the following?

❒ Aspirin
❒ Tetracycline
❒ Latex
❒ Penicillin
❒ Other
❒ Erythromycin
❒ Codeine
❒ Dental Anesthetics
❒ Tetracycline

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

_____

_____

DENTAL HISTORY:

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 work? ❍ Yes ❍ No

Do you have fears about going to the dentist? ❍ Yes ❍ No

Have you ever had gum treatment? ❍ Yes ❍ No

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

Your current dental health is: ❍ Good ❍ Fair ❍ Poor

Do you like your smile? ❍ Yes ❍ No

Do your gums ever bleed? ❍ Yes ❍ No

How many times a week do you floss? _____ Brush? _____

Type of bristles? ❍ Soft ❍ Medium ❍ Hard

How long do you use a toothbrush before replacing it? _____

Are your teeth sensitive to heat, cold, or anything else? _____

Have you lost any teeth? ❍ Yes ❍ No

If yes, why? _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform his office of any changes in my medical status. I authorize dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____
Signature Date

Payment is due in full at the time of treatment
unless prior arrangements have been approved.

If this office accepts insurance, I understand that I om responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental enrollment.
I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

_____
Signature Date

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

FOR OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient Named herein.

Initials: _____ Date: _____ / _____ / _____

MEDICAL HISTORY UPDATE:

I have read my medical history dated _____ / _____ / _____ and confirmed that it states past and present medical conditions.

_____
Signature Date

I have read my medical history dated _____ / _____ / _____ and confirmed that it states past and present medical conditions.

_____
Signature Date