Patient Information (CONFIDENTIAL)

How did you hear about us? _____

Prairie Skies Dentistry can now confirm appointments by Email or Text.
Please check your preference:

☐ Email ☐ Text ☐ Home Phone ☐ Cell Phone

PRAIRIE SKIES
FAMILY DENTISTRY

Name _____ Preferred Name _____ Birthdate _____ Home Phone _____ ☐ M ☐ F

Address _____ City _____ State _____ Zip _____

Email _____ SS# _____ Cell Phone _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

If Full Time Student, Name of School/College _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Person to contact in case of emergency _____ Phone _____

Responsible Party (IF SAME AS PATIENT, SKIP TO THE NEXT SECTION)

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Birthdate _____ Email _____ Cell Phone _____

Employer _____ Work Phone _____ SS# _____

Insurance Information (IF CARD(S) IS AVAILABLE, SKIP TO THE NEXT SECTION)

PRIMARY INSURANCE

Name of Insured _____

Relationship to Patient _____

Birthdate _____

SS#/ID# _____

Name of Employer _____

Insurance Company _____

Group # _____

Policy ID # _____

SECONDARY INSURANCE

Name of Insured _____

Relationship to Patient _____

Birthdate _____

SS#/ID# _____

Name of Employer _____

Insurance Company _____

Group # _____

Policy ID # _____

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

1. Have you ever been diagnosed with periodontal disease? _____

_____

2. How would you rate your smile on a scale from 1-10? _____

3. What changes would you make to improve your smile? _____

Over Please...

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 for any surgical operation or serious illness within the last 5 years?	☐	☐

If yes, please explain: _____

_____

_____

_____

_____

	Yes	No
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐

If yes, what medication(s) are you taking? _____

_____

_____

_____

_____

	Yes	No
4. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Lidocaine)	☐	☐
Penicillin or any other Antibiotics (Please list)	☐	☐

_____

Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Aspirin	☐	☐
Any Metals (e.g Nickel, Mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (Please list)	☐	☐

_____

_____

_____

_____

	Yes	No
5. Have you ever taken Fen-Phen/Redux?	☐	☐
6. Do you use tobacco?	☐	☐
7. Do you use controlled substances?	☐	☐
8. Do you have a history of substance abuse?	☐	☐
9. Are you taking any blood thinners?	☐	☐
10. Have you ever taken any bisphosphonates/ bone density medications?	☐	☐
11. Do you have Hepatitis or Jaundice?	☐	☐
12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐

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

	Yes	No		Yes	No
High Blood Pressure	☐	☐	Emphysema	☐	☐
Heart Attack	☐	☐	Cancer	☐	☐
Rheumatic Fever	☐	☐	Arthritis	☐	☐
Fainting/Seizures	☐	☐	Stroke	☐	☐
Asthma	☐	☐	Tuberculosis	☐	☐
Low Blood Pressure	☐	☐	Radiation Therapy	☐	☐
Epilepsy/Convulsions	☐	☐	Liver Disease	☐	☐
Leukemia	☐	☐	Heart Trouble	☐	☐
Diabetes	☐	☐	Respiratory Problems	☐	☐
Kidney Disease	☐	☐	Mitral Valve Prolapse	☐	☐
AIDS or HIV Infection	☐	☐	Joint Repl or Implant	☐	☐
Thyroid Problem	☐	☐	Anxiety/Depression	☐	☐
Heart Disease	☐	☐	Sinus Trouble	☐	☐
Cardiac Pacemaker	☐	☐	Other (please list)	☐	☐
Heart Murmur	☐	☐	_____		
Anemia	☐	☐	_____		

13. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

HIPAA Privacy Practices, Authorization and Release

I have read a copy of this office's Notice of Privacy Practices. By signing this form, I consent for your office to use and disclose my protected health information to carry out treatment, payment activities and healthcare operations. I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient *(or Parent/Guardian of Minor)* _____ Date _____