PATIENT INFORMATION

Date:_____

Name:_____ Birthdate:_____

If a minor, name of guardian(s):_____ Who may we thank for your referral?:_____

Street Address:_____

City/Prov:_____ Postal Code:_____

Email:_____ Home Phone:_____

Occupation:_____ Cell Phone:_____

Name of Spouse:_____ Spouse Birthdate:_____

Primary Insurance

Carrier:_____

Group #:_____

ID #:_____

Secondary Insurance

Carrier:_____

Group #:_____

ID #:_____

PERMISSION TO EMAIL AND/OR TEXT MESSAGE APPOINTMENT REMINDERS: ◯ YES ◯ NO

APPOINTMENTS: A $75 fee will be charged for missed or cancelled appointments without prior notification of 2 business days. Once an appointment has been scheduled, please remember that this time has been reserved for you.

INSURANCE: To avoid any misunderstanding regarding dental insurance, we wish our patients to know all professional services rendered are charged directly to the patient, and that patients are personally responsible for payment of fees. We do not render our services on the basis that insurance companies will pay our fees. Each fee is individual for the individual patient. Upon receipt of full payment of bill, we will prepare necessary forms or reports to help you obtain your benefits from your insurance company.

I CONSENT to taking of photographs and x-rays before, during and after treatment, and their use in scientific and educational papers and demonstrations.

I authorize release, to my dental benefits plan administrator and CDA, information contained in claims submitted electronically. This authorization shall continue in effect until the undersigned revokes the same.

Dr. Bradley M. Bishop Inc. complies with the 2004 Personal Information Protection Act (PIPA). Please be advised that your records may be shared with another dental office if a referral is required for your dental treatment and will be forwarded to your insurance company if required for pre-determination of payment of benefits.

Signature:_____ Date:_____

(If patient is a minor, signature of parent or guardian)

MEDICAL HISTORY

Patient Name:_____ Preferred Name:_____ Age:_____

Name of Physician/ and the specialty:_____

Last physical examination:_____ Purpose:_____

What is your estimate of your general health? ◯ Excellent ◯ Good ◯ Fair ◯ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
Hospitalization for illness or injury_____	◯	◯
An allergic reaction to:		
Aspirin, ibuprofen, acetaminophen, codeine	◯	◯
Penicillin	◯	◯
Latex	◯	◯
Other_____	◯	◯
Heart Problems, or stent within last 6 months_____	◯	◯
History of Infective Endocarditis_____	◯	◯
Artificial Heart Valve, Repaired Heart Defect_____	◯	◯
Pacemaker or implantable defibrillator_____	◯	◯
Stroke_____	◯	◯
High or Low Blood Pressure_____	◯	◯
Rheumatic or Scarlet Fever_____	◯	◯
Joint Replacement_____	◯	◯
High Cholesterol or taking Statin drugs_____	◯	◯
Tuberculosis _____	◯	◯
Asthma_____	◯	◯
Breathing or Sleep problems(ie Sleep Apnea)_____	◯	◯
Diabetes (Type:____)_____	◯	◯
Osteoporosis/Osteopenia(taking bisphosphonates)____	◯	◯
Liver Disease_____	◯	◯
Hepatitis (Type____)_____	◯	◯

	YES	NO
Arthritis_____	◯	◯
Kidney Disease_____	◯	◯
Thyroid or Parathyroid Disease _____	◯	◯
Glaucoma_____	◯	◯
Alcohol or Recreational Drug use_____	◯	◯
Head or Neck Injuries_____	◯	◯
Epilepsy, Seizures_____	◯	◯
Digestive Disorders (ie Celiac's, Gastric reflux)____	◯	◯
Prolonged bleeding due to a slight cut_____	◯	◯
Hives, Skin Rash, Hay fever_____	◯	◯
STI/STD/HPV_____	◯	◯
HIV/AIDS _____	◯	◯
Chemotherapy, immunosuppressive meds_____	◯	◯
Tumor, Abnormal Growth_____	◯	◯
Radiation Therapy_____	◯	◯
Psychiatric Treatment/ Emotional Difficulties____	◯	◯
ARE YOU:		
Presently being treated for any other illness____	◯	◯
A smoker or smoked previously_____	◯	◯
Often exhausted or Fatigued_____	◯	◯
FEMALE – pregnant_____	◯	◯
OTHER_____	◯	◯

Do you have any disability or condition not mentioned above? If so, please explain_____

_____

Describe any current medical treatment, impending surgery, genetic/developmental delay or other treatment that may possibly affect your dental treatment. (ie Botox, Collagen injections)_____

_____

Please list all medications, supplements, and or vitamins taken in the last 2 years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient Signature:_____ Date: _____

Doctor Signature:_____ Date: _____

DENTAL HISTORY

Name:_____ Preferred Name:_____ Age:_____

General (or previous) Dentist:_____ Last Dental Exam:_____

How would you rate the condition of your mouth? ◯ Excellent ◯ Good ◯ Fair ◯ Poor

I routinely see my dentist every: ◯ 3mo ◯ 4mo ◯ 6mo ◯ 12mo ◯ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PERSONAL HISTORY	**YES**	**NO**
Are you fearful of dental treatment? How fearful, on a scale of 1(least) to 10(most)_____	◯	◯
Have you had an unfavorable dental experience?_____	◯	◯
Have you ever had complications from past dental treatment?_____	◯	◯
Have you ever had trouble getting numb or had any bad reactions to local anesthetic?_____	◯	◯
Did you ever have braces, orthodontic treatment or had your bite adjusted?_____	◯	◯
Have you had any teeth removed?_____	◯	◯
GUM AND BONE		
Do your gums bleed or are they painful when brushing or flossing?_____	◯	◯
Have you ever been treated for gum disease or been told you have lost bone around your teeth?_	◯	◯
Have you ever noticed an unpleasant taste or odor in your mouth?_____	◯	◯
Is there anyone with a history of periodontal disease in your family?_____	◯	◯
Have you ever experienced gum recession?_____	◯	◯
Have you ever had any teeth come loose on their own?(without injury)_____	◯	◯
Have you experienced a burning sensation in your mouth?_____	◯	◯
TOOTH STRUCTURE		
Have you had any cavities in the past 3 years?_____	◯	◯
Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing?___	◯	◯
Do you feel or notice any holes (ie pitting, craters) on the biting surface of your teeth?_____	◯	◯
Are any teeth sensitive to hot, cold, biting, sweets or avoid brushing any part of your mouth?___	◯	◯
Do you have grooves or notches on your teeth near the gum line?_____	◯	◯
Have you ever broken or chipped teeth, had a toothache or cracked filling?_____	◯	◯
Do you frequently get food caught between any teeth?_____	◯	◯
BITE AND JAW JOINT		
Do you have problems with your jaw joint? (pain, sounds, locking, popping, limited opening)____	◯	◯
Do you feel like your lower jaw is being pushed back when you bite your teeth together?_____	◯	◯
Do you avoid or have difficulty chewing gum, bagels, carrots, nuts, or other hard, dry foods?____	◯	◯
Have your teeth changed in the last 5 years, become shorter, thinner or worn?_____	◯	◯
Are your teeth becoming more crooked, crowded or overlapped?_____	◯	◯
Are your teeth developing spaces or becoming looser?_____	◯	◯
Do you have more than 1 bite, squeeze, or shift your jaw to make your teeth fit together?_____	◯	◯
Do you place your tongue between your teeth or rest your tongue against your teeth?_____	◯	◯
Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?___	◯	◯
Do you clench your teeth in the daytime or make them sore?_____	◯	◯
Do you have any sleep problems, wake up with a headache or an awareness of your teeth? ____	◯	◯
Do you wear, or have you ever worn a bite appliance?_____	◯	◯
SMILE CHARACTERISITICS		
Is there anything about the appearance of your teeth that you would like to change?_____	◯	◯
Have you ever whitened (bleached) your teeth?_____	◯	◯
Have you felt uncomfortable or self-conscious about the appearance of your teeth?_____	◯	◯
Have you been disappointed with the appearance of previous dental work?_____	◯	◯

Patient Signature:_____ Date:_____

Doctor Signature:_____ Date:_____