BLINN
DENTAL

Patient Information

Patient Name: _____

SSN: _____

DOB: _____ Gender: ☐Male ☐Female

Email: _____

Address: _____

_____

Home Phone #: _____

Cell Phone #: _____

Referred By: _____

Occupation: _____

Employer: _____

Marital Status: ☐Married ☐Single

☐Widowed ☐Divorced ☐Minor

Spouse's Name: _____

Medications

List any medications you are currently taking: _____

_____

_____

Do you take blood thinners?: ☐Yes ☐No

☐NONE

Allergies

☐ Aspirin
☐ Barbiturates
☐ Codeine
☐ Iodine
☐ Latex
☐ Local Anesthetic
☐ Penicillin
☐ Sulfa
☐ Other _____
☐ NONE

Dental Insurance Information

Insurance Company: _____

Insurance Phone #: _____

Subscriber Name: _____

Relationship to Patient: _____

DOB: _____ SSN: _____

Group #: _____

I assign directly to Blinn Dental all insurance benefits, if any, otherwise payable to me or the insurance subscriber for services rendered on my behalf or my dependents. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize Blinn Dental to release all information necessary to secure the payment of insurance benefits. I authorize the use of this signature for all insurance submissions.

X _____

Emergency Contact

Name: _____

Phone #: _____

Relationship to Patient: _____

Pharmacy Information

Name: _____

Phone #: _____

Medical Insurance Information

Insurance Company: _____

Insurance Phone #: _____

Subscriber Name: _____

Relationship to Patient: _____

DOB: _____ SSN: _____

Group #: _____

Dental History

Former Dentist: _____ Phone #: _____

Date of last dental visit: _____

Please indicate if you have had any of the following:

Bad breath: ☐Yes ☐No

Bleeding gums: ☐Yes ☐No

Blisters on lip: ☐Yes ☐No

Burning sensation on tongue: ☐Yes ☐No

Chew on one side : ☐Yes ☐No

Dry mouth: ☐Yes ☐No

Food collection between teeth: ☐Yes ☐No

Grinding teeth: ☐Yes ☐No

Gums swollen or tender: ☐Yes ☐No

Jaw pain or tenderness: ☐Yes ☐No

Loose teeth or broken fillings: ☐Yes ☐No

Sensitivity to hot and/or cold: ☐Yes ☐No

Sensitivity to sweets: ☐Yes ☐No

Sensitivity when biting: ☐Yes ☐No

Sores or growths in mouth : ☐Yes ☐No

Tobacco Habit: ☐Yes ☐No

Have you ever seen a periodontist: ☐Yes ☐No

If yes which doctor and for what: _____

_____

Do you still have your wisdom teeth: ☐Yes ☐No

Are you missing any teeth: ☐Yes ☐No

Do you have any dental implants: ☐Yes ☐No

Do you have any crowns: ☐Yes ☐No

Do you have any fillings: ☐Yes ☐No

Have you ever had braces: ☐Yes ☐No

Do you currently wear a night guard: ☐Yes ☐No

Medical History

Physicians Name: _____ Phone #: _____

Date of last visit: _____

Have you ever taken any of the group drugs collectively referred to as “fen-phen”? ☐Yes ☐No

Please indicate if you have had any of the following:

Addiction: ☐Yes ☐No

AIDS/HIV: ☐Yes ☐No

Anemia: ☐Yes ☐No

Arthritis: ☐Yes ☐No

Artifical Valves/Joints : ☐Yes ☐No

Asthma: ☐Yes ☐No

Back Problems: ☐Yes ☐No

Bleeding Abnormally: ☐Yes ☐No

Blood Disease: ☐Yes ☐No

Cancer: ☐Yes ☐No

Chemotherapy: ☐Yes ☐No

Circulatory Problems: ☐Yes ☐No

Cough, persistent: ☐Yes ☐No

Diabetes: ☐Yes ☐No

Epilepsy: ☐Yes ☐No

Fainting or Dizziness: ☐Yes ☐No

Heart Disease: ☐Yes ☐No

Heart Murmur: ☐Yes ☐No

Hemophilia: ☐Yes ☐No

Hepatitis A: ☐Yes ☐No

Hepatitis B: ☐Yes ☐No

Hepatitis C: ☐Yes ☐No

Herpes (Oral): ☐Yes ☐No

High Blood Pressure: ☐Yes ☐No

Liver Disease: ☐Yes ☐No

Low Blood Pressure: ☐Yes ☐No

Mitral Valve Prolapsed: ☐Yes ☐No

Other Lung Disease: ☐Yes ☐No

Pacemaker: ☐Yes ☐No

PreMed: ☐Yes ☐No

Radiation Therapy: ☐Yes ☐No

Respiratory Disease: ☐Yes ☐No

Rheumatic Fever: ☐Yes ☐No

Scarlet Fever: ☐Yes ☐No

Sinus Trouble: ☐Yes ☐No

Stroke: ☐Yes ☐No

Swelling of feet or ankles: ☐Yes ☐No

Thyroid Problem: ☐Yes ☐No

Sleep Apnea/ CPAP: ☐Yes ☐No

X _____ _____

Patient Signature **Date**