Dr. Samira Davis DDS
Dr. Paul Benoit DDS
Family Dentistry

PAITENT INFORMATION (Confidential)

Name: _____ _____ Preferred Name: _____
Last First M

Home Address: _____
Apt # City State Zip Code

Birthdate: _____ Male Female Married Single Minor/Other

Home Phone #_(____)_____Work # _(____)_____Cell # _(____)_____
Ext.

Email: _____ If Student name of College_____
City

Billing Address: _____
If different than home Apt # City State Zip Code

Person to contact in case of emergency: _____ Phone #_(____)_____

Whom may we thank for referring you? _____

Responsible Party Name: _____ Phone #: _(____)_____

Relationship to patient: _____ SSN/ID #: _____Drivers License # _____

PRIMARY INSURANCE INFORMATION

Policyholder/Subscriber's Name: _____Relationship to patient: _____

Birthdate: _____ SS/ID # _____Group # _____

Employer: _____ Insurance Company: _____

Ins. Co. Address: _____
PO Box/Street City State Zip Code

Insurance Co. Phone # _____ Annual Maximum: _____

SECONDARY INSURANCE INFORMATION

Policyholder/Subscriber's Name: _____Relationship to patient: _____

Birthdate: _____ SS/ID # _____Group # _____

Employer: _____ Insurance Company: _____

Ins. Co. Address: _____
PO Box/Street City State Zip Code

Insurance Co. Phone # _____ Annual Maximum: _____

I certify that the above information is true, to the best of my knowledge. If any of this information changes, I will provide that information to Davis Family Dentistry as soon as possible. I understand that failure to provide accurate isurance information in a timely manner may result in being billed for the full fee for any services provided to me.

Signature: _____ Date: _____

Dr. Samira Davis DDS

Dr. Paul Benoit DDS

Family Dentistry

PATIENT MEDICAL HISTORY

Physician: _____ Office Phone#: _____ Last Exam: _____

Are you under medical treatment now? Yes No
Have you ever been hospitalized? Yes No
If yes please explain: _____
_____
Are you taking any medication(s) Yes No
Including non-prescription medications? Yes No
If yes what are you taking? _____
_____
Have you ever taken Fen-Phen/Redux Yes No
Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? Yes No
Have you ever used tobacco? Yes No
Do you use a controlled substance? Yes No

Are you wearing contact lenses? Yes No
Are you allergic to or have you had reactions to the following?
Local Anesthetic (e.g. Novocaine) Yes No
Penicillin or any other Antibiotics Yes No
Sulfa Drugs Yes No
Barbiturates Yes No
Sedatives Yes No
Iodine Yes No
Aspirin Yes No
Any Metals (e.g. nickel, mercury, etc.) Yes No
Latex Rubber Yes No
Other please list: _____

Women Only: **Pregnant/Trying to get pregnant? Yes No**
Taking oral contraceptives? Yes No
Nursing Yes No

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

High Blood Pressure…… Yes No
Heart Attack…… Yes No
Rheumatic Fever…… Yes No
Swollen Ankles…… Yes No
Fainting/Seizures…… Yes No
Asthma…… Yes No
Low Blood Pressure…… Yes No
Epilepsy/Convulsions…… Yes No
Joint Replacement or Implant…. Yes No
Diabetes…… Yes No
Kidney Disease…… Yes No
Sexually Transmitted Disease..... Yes No
Stomach Troubles/Ulcers…… Yes No

Heart Disease…… Yes No
Cardiac Pacemaker…… Yes No
Heart Murmur…… Yes No
Angina…… Yes No
Frequently Tired …… Yes No
Anemia…… Yes No
Emphysema…… Yes No
Cancer…… Yes No
Arthritis…… Yes No
Leukemia…… Yes No
Hepatitis/Jaundice…… Yes No
AIDS/HIV Infection…… Yes No
Thyroid Problem …… Yes No

Chest Pains…… Yes No
Easily Winded…… Yes No
Stroke…… Yes No
Hay Fever/Allergies…… Yes No
Tuberculosis…… Yes No
Radiation Therapy…… Yes No
Glaucoma…… Yes No
Recent Weight Loss…… Yes No
Liver Disease…… Yes No
Heart Trouble…… Yes No
Respiratory Problems…… Yes No
Mitral Valve Prolapse …… Yes No
Other: _____

PATIENT DENTAL HISTORY

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

Do your gums ever bleed while brushing or flossing? Yes No
Are your teeth sensitive to hot or cold liquids/foods Yes No
Are your teeth sensitive to sweet or sour liquids/foods Yes No
Have you ever had and difficult extractions in the past? Yes No
Do you have any sores or lumps in or near your mouth? Yes No
Have you had any orthodontic treatment? Yes No
Have you had any , neck or jaw injuries? Yes No
Have you ever experienced any of the following problems in your jaw? Yes No
Clicking…… Yes No
Pain (joint, ear, side of face) …… Yes No
Difficulty in opening, closing or chewing? Yes No

Do you have frequent headaches? Yes No
Do you clench or grind your teeth? Yes No
Do you bite your lips or cheeks frequently? Yes No
Do you feel pain to any of your teeth? Yes No
Have you ever had any prolonged bleeding after an extraction? Yes No
Do you wear dentures or partials? Yes No
If yes, date of placement _____
Have you ever received oral hygiene instructions regarding the care of your teeth and gums? Yes No
Do you like your smile? Yes No
Do you have a dry mouth? Yes No

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 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 tor dental group insurance benefits for the payment of all services rendered on my behalf or dependants.

_____

Signature of patient (or parent guardian if minor) Date