Cheek DENTAL

Patient Information

Date _____

Patient Name _____
Last Name

_____ _____ _____
First Name | Middle Initial | Name preferred to be called

Gender ☐ Male ☐ Female

☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced

Birthdate _____ **Age** _____

SSN _____

Address _____

City _____

State _____ **Zip** _____

E-Mail _____

Home # _____

Work # _____

Cell # _____

Patient Employer/School _____

Occupation _____

Employer Address _____

Spouse's Name _____

Spouse's Date of Birth _____

Spouse's Cell # _____

Spouse's Work # _____

Dental Insurance

Subscriber _____

Subscriber Date of Birth _____

Relationship to Patient _____

Insurance Company _____

Member ID # _____

Group # _____

ASSIGNMENT AND RELEASE
I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. Cristi Y. Cheek all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Dr. Cristi Y. Cheek may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents *for* the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.
NOTE: If remitting by e-mail or fax, patient will sign and date at first office visit.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date | Relationship to Patient

Emergency Contact Information

IN CASE OF EMERGENCY (Specify someone who does not live in your household)

Name of contact _____ **Relationship to Patient** _____

Home/Cell Phone _____ **Work Phone** _____

Dental History

Reason for today's visit
_____

Former Dentist _____

City/State _____

Date of last Dental visit _____

Date of last Dental X-rays _____

Bad breath	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Mouth Ulcers	☐ Yes	☐ No
Sores or growths in your mouth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Tobacco use	☐ Yes	☐ No
Alcohol use >1 drink per day	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Broken fillings / teeth	☐ Yes	☐ No
Foreign objects in facial-tissue	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Mouth pain, brushing	☐ Yes	☐ No
Braces / Orthodontics	☐ Yes	☐ No
Loose teeth	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No
Sensitivity to cold or heat	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No
Sensitivity when biting	☐ Yes	☐ No
Dental phobias	☐ Yes	☐ No
Jaw / Facial Surgery	☐ Yes	☐ No

How often do you brush? _____

How often do you floss? _____

How often do you have your teeth cleaned? _____

Health History

Physician's Name _____ **Date of last visit** _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Artificial Heart Valves	☐ Yes ☐ No	Cancer	☐ Yes ☐ No	Acid reflux	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No
Congenital Heart Lesions	☐ Yes ☐ No	Type _____		Problems swallowing	☐ Yes ☐ No	Thyroid problems	☐ Yes ☐ No
Heart Attack	☐ Yes ☐ No	Radiation	☐ Yes ☐ No	Severe gag reflex	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No
Heart Disease	☐ Yes ☐ No	Chemotherapy (dates)	☐ Yes ☐ No	Stomach Ulcer	☐ Yes ☐ No	A1C: _____	
Heart Murmur	☐ Yes ☐ No	_____		Tonsillitis	☐ Yes ☐ No	Epilepsy / Seizures	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No					Fainting / Dizziness	☐ Yes ☐ No
Low Blood Pressure	☐ Yes ☐ No	Anemia	☐ Yes ☐ No			Headaches	☐ Yes ☐ No
Mitral Valve Prolapse	☐ Yes ☐ No	Abnormal bleeding with extractions or surgery	☐ Yes ☐ No			Psychiatric disorder	☐ Yes ☐ No
Pacemaker	☐ Yes ☐ No	Blood Disease	☐ Yes ☐ No			Chemical Dependency	☐ Yes ☐ No
Stroke	☐ Yes ☐ No	Circulatory problems	☐ Yes ☐ No			Nervous problems	☐ Yes ☐ No
Swollen feet or ankles	☐ Yes ☐ No	Leukemia	☐ Yes ☐ No			Rheumatic / Scarlet Fever	☐ Yes ☐ No
Asthma	☐ Yes ☐ No					Tumor or growth on head or neck	☐ Yes ☐ No
CPAP Use		Artificial Joints	☐ Yes ☐ No			Swollen neck glands	☐ Yes ☐ No
Cough (persistent or bloody)	☐ Yes ☐ No	Arthritis / Rheumatism	☐ Yes ☐ No			Skin rash	☐ Yes ☐ No
COPD	☐ Yes ☐ No	Back problems	☐ Yes ☐ No			Hearing loss	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Cortisone treatments	☐ Yes ☐ No			Blindness	☐ Yes ☐ No
Respiratory Disease	☐ Yes ☐ No	Head / Neck injury	☐ Yes ☐ No			Glaucoma	☐ Yes ☐ No
Shortness of breath	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No			Diet restrictions	☐ Yes ☐ No
Sinus problems	☐ Yes ☐ No	Paralysis	☐ Yes ☐ No			Unexplained weight loss	☐ Yes ☐ No
Sleep Apnea	☐ Yes ☐ No						
Tuberculosis		AIDS / HIV	☐ Yes ☐ No				
Jaundice	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No				
Hepatitis	☐ Yes ☐ No	HPV	☐ Yes ☐ No				
Type_____		Herpes	☐ Yes ☐ No				

Women:

Are you pregnant? ☐ Yes ☐ No **Due Date** _____ **Taking birth control?** ☐ Yes ☐ No **Are you nursing?** ☐ Yes ☐ No

Please list all surgeries and corresponding dates _____

_____

Is there anything significant not listed above? _____

Medications

List any medications you are currently taking and the correlating diagnosis:

_____

_____

_____

Any blood thinners? ☐ Yes ☐ No

Any oral bisphosphonates? (osteoporosis type medications) ☐ Yes ☐ No

Allergies

☐ **Aspirin** ☐ **None** ☐ **Iodine**

☐ **Metals** ☐ **Local Anesthetic**

☐ **Codeine** ☐ **Penicillin**

☐ **Latex** ☐ **Sulfa**

Others _____

Special Needs

List any special concerns or requirements:

_____

_____

_____

_____

More Info

Whom may we thank for referring you? _____

How did you hear about our practice? _____

Are you happy with the appearance of your teeth? _____

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Dr. Initials