BOISE INTEGRATIVE DENTISTRY
EST. 1977

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ Sex: _____ Age: _____

Home Address: _____ City: _____ State ID Zip: _____

Billing Address: _____ City: _____ State ID Zip: _____

Home Phone: _____ Cell: _____ E-Mail: _____

SSN: _____ Employer/Occupation: _____ Bus. Phone: _____

Emergency Contact: _____ Relationship: _____ Emergency Phone: _____

Drivers License #: _____ Whom may we thank for referring you? _____

If the patient is a minor, who is legally responsible? _____

DENTAL HEALTH HISTORY

What is the reason for your visit today? _____

Are you happy with your teeth and their appearance? _____ If not, what would you like to see different? _____

Have you ever bleached your teeth? _____ Date of last visit to dentist: _____ Date of last dental x-rays: _____

Why did you leave your last dentist? _____

Please check any boxes you would answer "yes" to:

- ☐ Are you apprehensive about dental treatment?
- ☐ Have you had problems with previous dental care?
- ☐ Are you interested in nitrous oxide (laughing gas)?
- ☐ Are you interested in oral sedation for longer appointments? This involves taking oral medication before and during your appointment to help you relax and forget most, if not all, of your dental appointment?
- ☐ Do you have cold sores, aphthous ulcers (canker sores), or other sores in or about your mouth?
- ☐ Do you clench or grind your teeth frequently?
- ☐ Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activies?
- ☐ Have you ever had a TMJ problem?
- ☐ Do you get frequent or severe headaches?
- ☐ Are you interested in straightening crowded teeth or closing gaps between teeth?
- ☐ Are your teeth sensitive to hot, cold or sweets? Please list:

  _____
- ☐ Are you aware of an uncomfortable bite?
- ☐ Have you had a blow to the jaw (trauma)?
- ☐ Are you interested in a non-surgical way to stop you or your spouse from snoring?
- ☐ Are you tired, fatigued, or sleepy most days?
- ☐ Have you ever been told that you gasp for air or struggle to breathe at night?
- ☐ Have you ever bleached your teeth? If so, were you happy with the results?

  _____

How often do you brush? _____

Floss? _____

FINANCIAL POLICY

A service charge of 1.5% per month (18% annual rate) will be applied to balances over 60 days, $1.00 minimum charge. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to the insurance claim. If the patient is a minor, permission is granted for dental treatment, as deemed necessary to be performed in our office or until written notice is given discounting this permission.

I hereby authorize payment of the dental benefits directly to Dr. Steven Bruce, Dr. Robert Ririe, and Dr. Daniel Bruce.

Signature required _____ Date _____

MEDICAL HEALTH HISTORY

Please answer the following questions:

Physician name: _____ Date of last visit? _____ Condition treated: _____

Please list any medications you are taking, including prescription, over the counter, or herbal medications and/or supplements?

_____

Are you in good health? If there were any changes in your general health within the past year please describe them.

_____

Do you use tobacco (smoking, snuff, chew)? Frequency and amount: _____

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? If so, when? _____

Are you required by your physician to take premedication before dental treatment? _____

Do you currently take any bisphosphate medications for osteoporosis or cancer treatment (Fosamax, Actonal, Zometa, Aredia, Boniva, etc)? _____ If yes, which medication? _____

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

- ☐ Cancer/Tumor
  - If yes, were you treated with any of the following:
    - ☐ Surgery
    - ☐ Radiation
    - ☐ Chemotherapy
- ☐ Heart Problems
  - ☐ Chest pain
  - ☐ Shortness of breath
  - ☐ Blood pressure problem
  - ☐ Heart murmur
  - ☐ Heart valve problem
  - ☐ Pace maker
  - ☐ Artificial heart valve
- ☐ Blood Problems
  - ☐ Easy Bruising
  - ☐ Abnormal bleeding or blood disease
- ☐ Allergy Problems
  - ☐ Seasonal Allergies
  - ☐ Sinus problems
  - ☐ Asthma
- ☐ Intestinal Problems
  - ☐ Ulcers
  - ☐ Weight gain or loss
  - ☐ Frequent heartburn/GERD
  - ☐ Kidney or bladder problems
- ☐ Bone or Joint Problems
  - ☐ Arthritis
  - ☐ Back or neck pain
  - ☐ Joint replacement
- ☐ Diabetes
  - ☐ Family history of diabetes
  - ☐ Thirsty or mouth is dry most of the time
- ☐ Tuberculosis or other respiratory disease
- ☐ Hepatitis, jaundice, or liver trouble
- ☐ Sexually transmitted or blood born disease
  - If yes, which disease? _____
- ☐ Fainting spells, seizures, or epilepsy
- ☐ Stroke(s)
- ☐ Epilepsy or other neurological disease
- ☐ History of chemical dependancy
- ☐ Persistent cough or swollen glands
- ☐ Have you taken any diet drugs (Redux, Pondimin, or Phen-fen)
- ☐ Thyroid problems

Do you have any disease, condition, or problem not listed previously that you feel we should know about? If so, please describe.

_____

Are you allergic, or have you reacted adversely, to any of the following?

- ☐ Local anesthetics (e.g. Novocaine)
- ☐ Penicillin or other antibiotics
- ☐ Barbituates, sedatives, or sleeping pills
- ☐ Aspirin, Acetaminophen, or Ibuprofen
- ☐ Codeine, Demerol, or other narcotics
- ☐ Latex or rubber dam
- ☐ Sulfa drugs
- ☐ Reaction to metals

Other _____

During the past 12 months, have you taken any of the following?

- ☐ Antibiotics or sulfa drugs
- ☐ Anticoagulants (e.g. Coumadin)
- ☐ High blood pressure medicine
- ☐ Insulin, Orinase, or similar drugs
- ☐ Digitalis or drugs for heart trouble
- ☐ Tranquilizers
- ☐ Nonprescription drugs/supplements
- ☐ Natural remedies
- ☐ Aspirin
- ☐ Nitroglycerin
- ☐ Cortisone (steroids)

Other _____

Women - Please mark the box for each "yes" answer

- ☐ Are you taking contraceptives or hormones
- ☐ Are you nursing?
- ☐ Are you pregnant or do you think you might be pregnant?
- ☐ Have you reached menopause? If so, do you have symptoms? _____

I verify that the above information is correct to the best of my knowledge (Please Sign): _____