Blue Heron Dental

345 Bobwhite Court, Suite 140 | Boise, Idaho 83706 | (208) 345-1383

Date _____

Patient _____ Preferred Nickname _____

Home Phone _____ Work _____ Best Time To Reach You _____

Address _____

City _____ State _____ Zip _____

Sex: M F Age: _____ Birthday _____

S M W D

Patient SS# _____

Occupation _____

Employer _____

Employer Address _____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

Spouse's Employer _____

Spouse's Work # _____

Whom may we thank for referring you?

_____

IN CASE OF AN EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone _____

Work Phone _____

Who is responsible for this account?

_____

Relationship to Patient _____

Insurance Company _____

Group Number _____

Second Insurance? ☐ Yes ☐ No

Subscriber's Name _____

Insurance Company _____

Group Number _____

Thank you for your patience. We make every effort to keep on schedule, however patient comfort and anesthesia may require more time than planned. A truly caring attitude is extended to all of our patients.

I acknowledge full responsibility for the payment of dental services and agree to pay for them in full at the time of service unless other financial arrangements are made in advance with the business office manager. I ALSO UNDERSTAND THAT THERE IS A CHARGE FOR ALL MISSED APPOINTMENTS WITHOUT A 24 HOUR NOTICE.

Signature _____ Date _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Bowker all insurance benefits, if any, responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____

Relationship _____ Date _____

HEALTH HISTORY

Physician's Name _____ Date of Last Visit _____

MEDICAL

Artificial Heart Valves _____ ☐ Yes ☐ No
Artificial Joints _____ ☐ Yes ☐ No
Emphysema _____ ☐ Yes ☐ No
Asthma _____ ☐ Yes ☐ No
Blood Disease _____ ☐ Yes ☐ No
Cancer _____ ☐ Yes ☐ No
Diabetes _____ ☐ Yes ☐ No
Glaucoma _____ ☐ Yes ☐ No
Heart Murmur _____ ☐ Yes ☐ No
Mitral Valve Prolapse _____ ☐ Yes ☐ No
Rheumatic Fever _____ ☐ Yes ☐ No
Heart Problems _____ ☐ Yes ☐ No
Hepatitis _____ ☐ A ☐ B or ☐ C
Herpes _____ ☐ Oral or ☐ Other
High Blood Pressure _____ ☐ Yes ☐ No
HIV Positive _____ ☐ Yes ☐ No
Pregnant _____ ☐ Yes ☐ No
Due Date _____
Radiation Treatment _____ ☐ Yes ☐ No
Reaction to Local Anesthetic _____ ☐ Yes ☐ No
Seizure Disorder _____ ☐ Yes ☐ No

MEDICATIONS

List medications you are currently taking: _____

_____

_____

_____

Pharmacy Name _____

Pharmacy Phone _____

Allergies

Aspirin _____ ☐ Yes ☐ No
Barbiturates(Sleeping Pills) _____ ☐ Yes ☐ No
Codeine _____ ☐ Yes ☐ No
Ibuprofen _____ ☐ Yes ☐ No
Latex _____ ☐ Yes ☐ No
Penicillin _____ ☐ Yes ☐ No
Sulfa _____ ☐ Yes ☐ No
Other _____ ☐ Yes ☐ No
What? _____

_____

_____

_____

Approximate Date of Last X-Rays? _____ Approximate Date of Last Cleaning? _____

Approximate Date of Last Visit to the Dentist? _____ Previous Dentist's Name _____

DENTAL INFORMATION

Are you presently having dental pain? ☐ Yes ☐ No
Do you want to improve the appearance of your teeth? ☐ Yes ☐ No
Do you have a denture or a partial denture? ☐ Yes ☐ No
Are you aware of any decayed teeth or lost fillings? ☐ Yes ☐ No
Are your teeth sensitive to heat ☐ cold ☐ sweets ☐ or bite pressure ☐ ? ☐ Yes ☐ No
Are you ever aware of prolonged periods of bad breath? ☐ Yes ☐ No
Do your gums bleed when you brush? ☐ Yes ☐ No
Do you clench or grind your teeth? ☐ Yes ☐ No
Does your jaw "pop" or click routinely? ☐ Yes ☐ No
Have you ever experienced any unfavorable dental treatment? ☐ Yes ☐ No
Have you had professional instruction on home care? ☐ Yes ☐ No
Do you have regular checkups? ☐ Yes ☐ No
Do you prefer Nitrous Oxide (gas) with your dental treatments? ☐ Yes ☐ No

PEDIATRIC INFORMATION

Does your child have any speech ☐ learning ☐ or hearing disorders ☐ ? ☐ Yes ☐ No
Does your child brush daily? ☐ Yes ☐ No
Do you assist your child with brushing ☐ How often? _____ ☐ Yes ☐ No
Is dental floss used? ☐ Yes ☐ No
How does your child receive fluoride? Water ☐ Toothpaste ☐ Dentist ☐ Vitamin Tablet ☐ None ☐ Other _____
Any mouth habits: Thumbsucking ☐ Nail Biting ☐ Mouth Breathing ☐ Etc. ☐ ? ☐ Yes ☐ No