Christopher B. Clark, D.D.S. Inc.
Coventry Woods Executive Park
28321 Kensington Lane
Perrysburg, Ohio 43551
419.874.3333
chrisclarkdds.com

Welcome

Patient Information

First Name: ____________________ Last Name: _________________________ Middle Initial: _______ Preferred Name: _________________

Address: ____ City: ___________________________ State/Zip: ______________________

Employer: ____________________________ Address: _________________________________ Occupation: __________________________

Home Phone: ______________ Work Phone: ______________ Ext: ______ Cellular: _____________ Email: __________________________

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: __________________________________ Age: ______________________ Soc. Sec: ___________________________________

Names and ages of family members: ____

Do all family members live at the same address? ____

Emergency Contact: ____________________ Address: ___________________________ Phone: ______________ Relationship____________

Who may we thank for referring you to our office?: ____

Spouse Information

First Name: ____________________ Last Name: _________________________ Middle Initial: _______ Preferred Name: _________________

Address: ____ City: ___________________________ State/Zip: ______________________

Employer: ____________________________ Address: _________________________________ Occupation: __________________________

Home Phone: _________________ Work Phone: _________________ Ext: _______ Cellular: ________________ Email: ________________

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: __________________________________ Age: ______________________ Soc. Sec: ___________________________________

Responsible Party (if someone other than the patient)

First Name: _____________________________ Last Name: ____ Middle Initial: ____________

Address: ____ Address (2): ____

City: ____________________________ State/Zip: __________________________ Employer: ______________________________________

Home Phone: _________________ Work Phone: _________________ Ext: _______ Cellular: ________________ Email: ________________

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: __________________________________ Age: ______________________ Soc. Sec: ___________________________________

☐ Responsible Party is also a policy holder for Patient ☐ Primary Insurance Holder ☐ Secondary Insurance Policy Holder

Primary Insurance Information

Your Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of insured: ____________________________________

Insured Soc. Sec: ___________________________________

Employer: ____

Address: ____

Address (2): ____

City, State, Zip: _____________________________________

Insured Birth Date: ____________________________________

Insurance Company: ____________________________________

Address: ____

Address (2): ____

City, State, Zip: _______________________________________

Secondary Insurance Information

Your Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of insured: ____________________________________

Insured Soc. Sec: ___________________________________

Employer: ____

Address: ____

Address (2): ____

City, State, Zip: _____________________________________

Insured Birth Date: ____________________________________

Insurance Company: ____________________________________

Address: ____

Address (2): ____

City, State, Zip: _______________________________________

Dental History

Reason for visit today ____________________
____
Former Dentist ____________________________
City/State ____________ Phone ____________
Date of last dental visit ____________________
Date of last dental x-rays ___________________

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

Bad breath ☐ Yes ☐ No
Bleeding gums ☐ Yes ☐ No
Burning sensation on tongue ☐ Yes ☐ No
Chew on one side of mouth ☐ Yes ☐ No

Clicking or popping jaw ☐ Yes ☐ No
Dry Mouth ☐ Yes ☐ No
Fingernail biting ☐ Yes ☐ No
Food collection between teeth ☐ Yes ☐ No
Grinding teeth ☐ Yes ☐ No
Gums swollen or tender ☐ Yes ☐ No
Jaw pain or tiredness ☐ Yes ☐ No
Lip or cheek biting ☐ Yes ☐ No
Loose teeth, broken teeth or fillings ☐ Yes ☐ No
Mouth breathing ☐ Yes ☐ No
Orthodontic treatment ☐ Yes ☐ No
if yes, when _________________
Periodontal treatment ☐ Yes ☐ No
if yes, when _________________

Previous extractions ☐ Yes ☐ No
if yes, when______________
Sensitivity to cold ☐ Yes ☐ No
Sensitivity to heat ☐ Yes ☐ No
Sensitivity to sweets ☐ Yes ☐ No
Sensitivity when biting ☐ Yes ☐ No
Sores or growths in your mouth ☐ Yes ☐ No
How often do you floss ____________________
How often do you brush ____________________
Have you used Nitrous Oxide? ☐ Yes ☐ No
Would you like Nitrous Oxide? ☐ Yes ☐ No
Would you like your teeth whiter? ☐ Yes ☐ No
Is there anything you wish you could change about your smile? ☐ Yes ☐ No
____

Medical History

Name of Primary Care Physician ___________________________ Address ____________________________ Phone ______________________

Date of last physical exam ____________

Are you under a physician’s care now? ☐ Yes ☐ No If yes, please explain: ______________________________________

Have you ever been hosptialized or had a major operation? ☐ Yes ☐ No If yes, please explain: ______________________________________

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain: ______________________________________

Do you have or have you ever had a drug/alcohol addiction? ☐ Yes ☐ No If yes, please explain: ______________________________________

Do you use tobacco? ☐ Yes ☐ No If yes, ☐ Cigarette ☐ Pipe/Cigar ☐ Smokeless tobacco

Additional information so that we may give you the best possible care ____
____

Please answer all questions

Cardiovascular Disease ☐ Yes ☐ No
Angina ☐ Yes ☐ No
Bacterial Endocarditis ☐ Yes ☐ No
Chest Pains ☐ Yes ☐ No
Congenital Heart Defect ☐ Yes ☐ No
Congestive Heart Failure ☐ Yes ☐ No
Easily Winded ☐ Yes ☐ No
Heart Attack ☐ Yes ☐ No
Heart Defibrillator ☐ Yes ☐ No
Heart Murmur ☐ Yes ☐ No
High/Low Blood Pressure ☐ Yes ☐ No
Irregular Heart Beat ☐ Yes ☐ No
Pacemaker ☐ Yes ☐ No
Stroke CVA/MIA ☐ Yes ☐ No

Anemia ☐ Yes ☐ No
Blood Disease ☐ Yes ☐ No
Blood Transfusion ☐ Yes ☐ No
Bruise Easily ☐ Yes ☐ No
Excessive Bleeding ☐ Yes ☐ No
Hemophilia ☐ Yes ☐ No
Leukemia ☐ Yes ☐ No
Sickle Cell Disease ☐ Yes ☐ No

Cold Sores/Fever Blisters ☐ Yes ☐ No
Herpes I, II, Genital ☐ Yes ☐ No
Human Papilloma Virus (HPV) ☐ Yes ☐ No
Hepatitis A, B, C ☐ Yes ☐ No
Sexually Transmitted Disease ☐ Yes ☐ No

Cancer ☐ Yes ☐ No
Chemotherapy ☐ Yes ☐ No
Radiation Treatments ☐ Yes ☐ No

Diabetes ☐ Yes ☐ No
Dialysis ☐ Yes ☐ No
Excessive: Thirst/Urination ☐ Yes ☐ No
Hypoglycemic ☐ Yes ☐ No
Jaundice ☐ Yes ☐ No
Kidney Problems ☐ Yes ☐ No
Liver Disease ☐ Yes ☐ No

Asthma ☐ Yes ☐ No
Breathing Problems/Respiratory ☐ Yes ☐ No
Emphysema ☐ Yes ☐ No
Hay Fever ☐ Yes ☐ No
Lung Disease ☐ Yes ☐ No
Tuberculosis ☐ Yes ☐ No

Auto Immune Disease ☐ Yes ☐ No
Sjogen Disease ☐ Yes ☐ No
Rheumatoid Arthritis ☐ Yes ☐ No
Lichen Planus ☐ Yes ☐ No

Alzheimer’s Disease ☐ Yes ☐ No
Arthritis ☐ Yes ☐ No
Cortisone Medicine ☐ Yes ☐ No
Glaucoma ☐ Yes ☐ No
Osteoporosis ☐ Yes ☐ No
Shingles ☐ Yes ☐ No

Convulsions ☐ Yes ☐ No
Epilepsy/Seizures ☐ Yes ☐ No
Fainting Spells/Dizziness ☐ Yes ☐ No

Hyperthyroid Disease ☐ Yes ☐ No
Hypothyroid Disease ☐ Yes ☐ No
Parathyroid Disease ☐ Yes ☐ No

ADD/ADHD ☐ Yes ☐ No
Anaphylaxis ☐ Yes ☐ No
Depression ☐ Yes ☐ No
Drug/Alcohol Addiction ☐ Yes ☐ No
Mental Disability ☐ Yes ☐ No
Nervous/Anxiety Disorders ☐ Yes ☐ No
Psychiatric Care ☐ Yes ☐ No

Others:
Do you wear contacts ☐ Yes ☐ No
Dry Mouth ☐ Yes ☐ No
Frequent Cough ☐ Yes ☐ No
Frequent Diarrhea ☐ Yes ☐ No
Frequent Headaches ☐ Yes ☐ No
Hives/Rash ☐ Yes ☐ No
Pain in Jaw Joints ☐ Yes ☐ No
Recent Weight Loss ☐ Yes ☐ No
Sinus Trouble ☐ Yes ☐ No
Sleep Apnea ☐ Yes ☐ No
Snoring Problem ☐ Yes ☐ No
Swelling of Limbs ☐ Yes ☐ No
Stomach/Intestinal Disease ☐ Yes ☐ No
Tonsillitis ☐ Yes ☐ No
Ulcers ☐ Yes ☐ No

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please explain: ______________________________________
____

Additional Medical Information

Bisphosphonates*: **Do you take** ☐ Yes ☐ No **Have you taken** ☐ Yes ☐ No **Do plan to take** ☐ Yes ☐ No

(*drugs used to treat bone loss, osteoporosis, metastatic cancer, multiple mylenoma, breast cancer, prostate cancer and pagets disease) (Example: Actonel, Aredia, Boniva Fosamax)

If yes to Bisphosphonates, do you take it **Orally** ☐ Yes ☐ No **IV** ☐ Yes ☐ No **Drug's Name** ______________________________

How long? _______________ **Dosage** ___________ **Diagnosis** ______________________________

Prescribing Physician's Name: ________________________ Address: _____________________________________ Phone:____________________

Do you have a prosthetic (Artificial) ☐ Yes ☐ No ________ **Knee** _______ **Hip** _______**Other** _______

Name of Orthopedic Surgeon: ______________________________________ Phone: _____________________ Date of Treatment: _______________

Do you have diabetes? ☐ Yes ☐ No **if yes, treated with** ☐ No Medication ☐ Oral Medication ☐ Injected Medication

Do you have any of the following heart conditions? ☐ Yes ☐ No ☐ Prosthetic cardiac valve ☐ Previous infective endocarditis ☐ Specific congenital disease ☐ Heart transplant

Name of Cardiologist: ____ Phone: _____________________ Date of Treatment: ______________

Woman: Are you

Pregnant? ☐ Yes ☐ No Trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to any of the following?

Aspirin ☐ Penicillin ☐ Codeine ☐ Nickel ☐ Latex ☐ Local Anesthetics ☐ NSAIDS ☐ Sulfa ☐ Metals ☐ **No known Allergies** ☐ Other ☐

If yes, please explain: ____

Please list all Prescription/OTC medications you are currently taking and reason (Including Herbal Supplements)

Medication	Reason

Please read and initial the following

Please read and initial the following

________ I understand that I am financially responsible for all charges whether or not paid by insurance.
________ I authorize Dr. Clark and his staff to perform all necessary dental services.
________ I authorize Dr. Clark to release and receive information to and from my physicians, and other health care providers.
________ I authorize the use of this signature on all insurance submissions.
________ I authorize the insurance company to pay Dr. Clark all insurance benefits otherwise payable to me for services performed.
________ To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Date _______________________ **Signature** ____

B/P ___________ P __________ Date __________________________________

(STOP) **THESE UPDATES ARE FOR FUTURE USE** (STOP)

B/P __________ There HAS/HAS NOT been a change in my medical history. Initial ________________ Date______________________
P __________ If yes, please explain ____

B/P __________ There HAS/HAS NOT been a change in my medical history. Initial ________________ Date ______________________
P __________ If yes, please explain ____

B/P __________ There HAS/HAS NOT been a change in my medical history. Initial ________________ Date ______________________
P __________ If yes, please explain ____

B/P __________ There HAS/HAS NOT been a change in my medical history. Initial ________________ Date ______________________
P __________ If yes, please explain ____