

Casey Dental Institute P.C.

1. Patient Information (confidential)

Name: _____ Birthday: _____ Soc. Sec. # _____
Address: _____ City: _____ State: _____ Zip: _____
Home: () _____ Work: () _____ Ext: _____ Cell Phone () _____
E-Mail _____ Sex M F

 Married Widowed Single Minor
 Separated Divorced

Occupation _____ Patient Employer _____

Spouse or Parent's Name _____

Whom May We Thank for Referring You? _____

In Case of an Emergency, Contact (Specify Someone who does not live in your household)

Name: _____ Relationship: _____

Home phone: () _____ Work Phone: () _____

2. Dental Insurance

Who is Responsible for this Account? _____

Relationship to Patient: _____

Birthday: _____ Soc. Sec. # _____

Insurance Company: _____ Group # _____

Is Patient Covered by Additional Insurance: yes no

Subscriber's Name: _____

Relationship to Patient: _____

Birthday: _____ Soc. Sec. # _____

Insurance Company: _____ Group # _____

Assignment and Release

I Certify that I, and/or my dependent(s), have insurance coverage and assign directly to Casey Dental Institute P.C. 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.

Date: _____

(Signature of Patient, Parent, Guardian or Personal Representative)

3. Dental History

Reason for today's visit _____

Date of last dental visit _____

Date of last dental x-rays _____

Do you like the color of your teeth? _____

Do you like your smile? _____

Do you like the size and shape of your teeth? _____

How often do you floss? _____

How often do you brush? _____

Bad breath	<input type="checkbox"/> yes <input type="checkbox"/> no	Jaw pain or tiredness	<input type="checkbox"/> yes <input type="checkbox"/> no
Bleeding gums	<input type="checkbox"/> yes <input type="checkbox"/> no	Lip or cheek biting	<input type="checkbox"/> yes <input type="checkbox"/> no
Blisters on lips or mouth	<input type="checkbox"/> yes <input type="checkbox"/> no	Loose teeth or broken fillings	<input type="checkbox"/> yes <input type="checkbox"/> no
Burning sensation on tongue	<input type="checkbox"/> yes <input type="checkbox"/> no	Mouth breathing	<input type="checkbox"/> yes <input type="checkbox"/> no
Chew on one side of mouth	<input type="checkbox"/> yes <input type="checkbox"/> no	Mouth pain, brushing	<input type="checkbox"/> yes <input type="checkbox"/> no
Cigarette, pipe, or cigar smoking	<input type="checkbox"/> yes <input type="checkbox"/> no	Orthodontic treatment	<input type="checkbox"/> yes <input type="checkbox"/> no
Clicking or popping jaw	<input type="checkbox"/> yes <input type="checkbox"/> no	Pain around ear	<input type="checkbox"/> yes <input type="checkbox"/> no
Dry mouth	<input type="checkbox"/> yes <input type="checkbox"/> no	Periodontal treatment	<input type="checkbox"/> yes <input type="checkbox"/> no
Fingernail biting	<input type="checkbox"/> yes <input type="checkbox"/> no	Sensitivity to cold	<input type="checkbox"/> yes <input type="checkbox"/> no
Food collection between the teeth	<input type="checkbox"/> yes <input type="checkbox"/> no	Sensitivity to heat	<input type="checkbox"/> yes <input type="checkbox"/> no
Foreign objects	<input type="checkbox"/> yes <input type="checkbox"/> no	Sensitivity to sweets	<input type="checkbox"/> yes <input type="checkbox"/> no
Grinding teeth	<input type="checkbox"/> yes <input type="checkbox"/> no	Sensitivity when biting	<input type="checkbox"/> yes <input type="checkbox"/> no
Gums swollen or tender	<input type="checkbox"/> yes <input type="checkbox"/> no	Sores or growths in your mouth	<input type="checkbox"/> yes <input type="checkbox"/> no

Please read the following

Our practice prefers to do "white" composite restorations instead of "silver" amalgam restorations. The Casey Dental Institute takes the position that "white" fillings bond to the tooth are stronger and function better with your other teeth. A handout will be provided.

Thank You,
Dr. Shawn Casey

4. Medical 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:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis Type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally, with extractions or surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Feet or Ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor or growth on head or neck	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, persistent or bloody	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss, unexplained	<input type="checkbox"/> Yes <input type="checkbox"/> No

Do you wear contact lenses? Yes No

Women:

Are you pregnant? Yes No

Due date _____

Are you nursing? Yes No

Taking birth control pills? Yes No

Medications

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

Allergies

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Local Anesthetic
<input type="checkbox"/> Barbiturates (sleeping pills)	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Codeine	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Iodine	<input type="checkbox"/> Other _____
<input type="checkbox"/> Latex	_____

Patient's signature: _____ Date: _____

Doctor's Comments: _____

Doctors Signature: _____ Date: _____