Welcome to Polo Dental!

Patient Information

Name: _____ Preferred Name: _____

Address: _____ City: _____ State _____ Zip: _____

Home #: _____ Work #: _____ Cell #: _____

Email: _____

Sex (circle): **M / F** Birth Date: _____ /_____ /_____ SSN:_____

Family Status (circle): **Single Married Divorced Child** Partner's Name: _____

Whom may we thank for referring you to our practice?_____

Contact Information

What is the best way to communicate with you (circle)? **Home Phone / Cell Phone / Work Phone**

How would you like to receive Appointment Reminders (circle)? **Call My Home Phone / Call My Cell Phone / Text Me**

In the event of an emergency, whom should we contact? Name _____

Relationship_____ Phone #: _____

Dental Insurance Information (Primary)

Name of Subscriber: _____ Relationship to patient: _____

Subscriber Birth Date: _____ /_____ /_____ Subscriber SSN:_____

Subscriber Employer Name: _____

Insurance Carrier: _____ Insurance Co Phone #: _____

Claims Address:_____

City, State, Zip: _____

Group #: _____ID #: _____

Dental Insurance Information (Secondary)

Name of Subscriber: _____ Relationship to patient: _____

Subscriber Birth Date: _____ /_____ /_____ Subscriber SSN:_____

Subscriber Employer Name: _____

Insurance Carrier: _____ Insurance Co Phone #: _____

Claims Address:_____

City, State, Zip: _____

Group #: _____ID #: _____

Medical History

Have you ever had or currently experiencing any of the following? (Please check all that apply)

- ❑ Pacemaker
- ❑ Artificial heart valve
- ❑ Heart Attack / Stroke
- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Use/Carry Nitroglycerin
- ❑ Endocarditis (heart infection)
- ❑ Congenital Heart Defects
- ❑ Heart Bypass or Stent
- ❑ Angina (Chest Pain)
- ❑ Anemia / Leukemia
- ❑ Acid Reflux/GERD
- ❑ Cancer - Date: _____
  Type: _____
- ❑ Radiation / Chemotherapy
- ❑ Diabetes Type I or Type II
- ❑ Osteoporosis
- ❑ Kidney Issues
- ❑ Thyroid Disease
- ❑ Tuberculosis
- ❑ Hepatitis / Liver Disease
- ❑ HIV / AIDS
- ❑ Sinus Troubles
- ❑ Seasonal Allergies
- ❑ Hay Fever
- ❑ Asthma
- ❑ Eating Disorder(s)
- ❑ Rheumatoid Arthritis
- ❑ Fainting
- ❑ Bleeding Disorder
- ❑ Difficulty Hearing
- ❑ Artificial Joints
  Type: _____
  Date: _____
- ❑ Mental Health Disorder
  Type: _____
- ❑ Epilepsy / Seizure
- ❑ Autoimmune Disease
- ❑ Back Problems
- ❑ Arthritis
- ❑ Tobacco Use
- ❑ Swelling of Hands/Feet
- ❑ Jaw Pain
- ❑ Glaucoma
- ❑ Heart Murmur
- ❑ Rheumatic Fever
- ❑ Severe Headaches

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1. Date of last physical exam: _____

Physician's Name: _____ Facility Name: _____

2. Have you ever been hospitalized (if yes, explain below)? **Yes / No**

_____

_____

3. Have you been under the care of a medical doctor during the past two years (if yes, explain below)? **Yes / No**

_____

_____

4. Have you ever had any excessive bleeding requiring special treatment? **Yes / No**

5. Are you allergic to or have you had an allergic reaction to any of the following (please circle if yes):

Local Anesthetic **Codeine** **Cephalosporin/Cephalexin** **Metals** **Latex**

Penicillin / Amoxicillin **Sulfa** **Ibuprofen** **Aspirin** **Iodine**

Other: _____

7. Are you taking or have you ever taken any of the following Osteoporosis medications (please circle if yes):

Fosamax **Actonel** **Boniva** **Aredia** **Reclast** **Zometa**

For how long? _____ When did you stop? _____

8. Are you taking any blood thinners? **Yes / No** If yes, please list: _____

9. Do you take Premedication before dental appointments? **Yes / No** If yes, please list: _____

9. Please list other medications you are taking (if you have a medication list, we will make a copy):

_____

_____

Dental History

1. Date of last dental exam:_____ Date of last dental x-rays: _____

2. Previous dentist's name / location:_____

3. Are you having tooth or gum pain at this time? **Yes / No**

4. Do you feel nervous about having dental treatment? **Yes / No**

5. Have you ever had a bad experience in a dental office? **Yes / No**

6. Do your gums bleed when brushing / flossing? **Yes / No**

7. Have you ever seen a periodontist? **Yes / No**

8. Have you ever had a “deep cleaning” (Scaling and Root Planing)? **Yes / No**

9. Are you currently having any dental issues/concerns you’d like to discuss with Dr. Clayton (if yes, please explain):

_____

_____

Do you or have you had any of the following (Please select all that apply):

- ❏ Clicking, popping, or discomfort in the jaw
- ❏ Sensitivity to: *Hot* *Cold* *Sweets* *Pressure*
- ❏ Pain in or around your ears
- ❏ Swelling
- ❏ Bleeding Gums
- ❏ Difficulty opening or closing
- ❏ Bad Breath / Bad Taste
- ❏ Difficulty chewing
- ❏ Food Catching
- ❏ Tooth Pain
- ❏ History of trauma to jaw or face
- ❏ Clenching
- ❏ Grinding
- ❏ Diagnosis of TMJ/TMD
- ❏ Orthodontic treatment (braces)
- ❏ Dentures/Partials
- ❏ Sore / Ulcers in mouth
- ❏ Other: _____

I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate.

Signature_____ Date_____