**Molly E. Vendetti, DMD Carly M. Peterschmidt, DMD** 10 Coburg Road, Suite 202

Eugene, OR 97401

(541) 485-1131 • Fax (541) 505-7709

First Name: Last Name: Middle Initial:

Preferred Name: Whom may we thank for referring you to our office?:

Address:

City: State / Zip

Home Phone: Work Phone: Ext: Cellular:

Sex: Male Female Marital Status: Married Single Divorced Separated Widowed Spouse’s Name:

Pts Birth Date: Age Soc Sec: Driver’s Lic:

Email: Prefer to be contacted at: Home Phone Cell Phone Work Phone Employer:

Student Status: Full Time Part Time School Attending:

## Responsible Party (if someone other than patient)

First Name: Last Name: Middle Initial:

Address:

City: State / Zip

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Driver’s Lic:

## Primary Insurance Information

Name of Insured: Relationship to Insured: Self Spouse Child Other Insured ID#: Insured Birth Date: Group#:

Employer: Ins. Company:

Insured’s Address (if different than pt): Address:

 Address 2:

 City, State, Zip:

 Ins. Co. Phone #:

## Secondary Insurance Information

Name of Insured: Relationship to Insured: Self Spouse Child Other Insured ID#: Insured Birth Date: Group#:

Employer: Ins. Company:

Insured’s Address (if different than pt): Address:

 Address 2:

 City, State, Zip:

 Ins. Co. Phone #:

**NOTE: We bill the insurance company as a convenience to the patient. Insurance coverage quoted is only an estimation based on information provided. Guarantor is responsible for all treatment not covered by insurance.**

Signature: Date:

# MEDICALHISTORY

Physician’s name Phone No. How would you describe your health? Date of last physical Have you been hospitalized or under a physician’s care in the last 2 years? For?

List any medications you are taking

Have you ever had an adverse reaction or allergies to any medication or substance? (Please circle)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Aspirin | Valium | Sulfa Drugs | Penicillin | Erythromycin |  |
| Codeine | Acrylic | Metal | Latex | Local Anesthetics | Other  |

Are you under a physician’s care now? Yes No If yes, please explain Have you ever been hospitalized or had a major operation? Yes No If yes, please explain Have you ever had a serious neck injury? Yes No If yes, please explain Have you ever taken Boniva, Fosomax or any other medication containing Bisphosphonates? Yes No

Are you on a special diet? Yes No If yes, please explain Do you use tobacco? Yes No

Do you use controlled substances? Yes No

Women are you: Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

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

AIDS/HIV

Alzheimer’s Disease Anaphylaxis

Anemia Angina

Arthritis/Gout

Artificial Heart Valve Artificial Joint

Pre-Med Asthma

Blood Disease Blood Transfusion Breathing Problem Bruise Easily Cancer Chemotherapy Chest Pains

Cold Sores/Fever Blisters Congenital Heart Disorder Convulsions

No Cortisone Medicine No Diabetes

No Drug Addiction

Yes

Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes

No Easily Winded

No Emphysema

No Epilepsy or Seizures No Excessive Bleeding No Excessive Thirst

No Fainting Spells/ Dizziness No Frequent Cough

No Frequent Diarrhea No Frequent Headaches No Genital Herpes

No Glaucoma

No Hay Fever

No Heart Attack/Failure No Heart Murmur

No Pre-Med

No Heart Pacemaker

No Heart Trouble/Disease

No Hemophilia

No Hepatitis A

Yes

Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes

No Hepatitis B or C No Herpes

No High Blood Pressure No High Cholesterol

No Hives or Rash No Hypoglycemia

No Irregular Heartbeat No Kidney Problems No Leukemia

No Liver Disease

No Low Blood Pressure No Lung Disease

No Mitral Valve Prolapse No Osteoporosis

No Pain in Jaw Joints No Parathyroid Disease No Psychiatric Care

No

No Radiation Treatment No

No Recent Weight Loss No

Yes

Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes

Yes

Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes

No Renal Dialysis No

No Rheumatic Fever No

No Rheumatism No

No Scarlet Fever No

No Shingles No

No Sickle Cell Disease No

No Sinus Trouble No

No Spina Bifida No

No Stomach/Intestinal Disease No

No Stroke No

No Swelling of Limbs No

No Thyroid Disese No

No Tonsillitis No

No Tuberculosis No

No Tumors or Growths No

No Ulcers No

No Venereal Disease No

Yellow Jaundice No

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

Pre-medication required before dental treatment? Yes No

Rx Information Preferred Pharmacy

**DENTAL HISTORY**

Do you have problems getting numb?

Yes No

Are you interested in whitening your teeth?

Yes No

Do you currently have problems with any of the following?

|  |  |  |  |
| --- | --- | --- | --- |
| Bleeding gums | Headaches or neck pain | Bad breath | Grinding or clenching of teeth |
| Unpleasant taste | Sore areas in the mouth | Loose or chipped teeth | Broken teeth |
| Missing teeth | Teeth sensitive to pressure | Pain when chewing | Hot / cold tooth sensitivity |
| Jaw(s) clicking or popping | Sweet sensitive teeth | Other |  |

**CANCELLATION POLICY**

**We require 24-hour notice. Otherwise,a charge will be made for the time reserved for you. If you fail to show up for a second appointment, you will be charged for the cost of the treatment to be rendered. For a failed third appointment, you will be dismissed asa patient.**

I hereby authorize this Practice to administer treatment, x-rays, and anesthetics to perform dental procedures as deemed necessary or advisable in the diagnosis and treatment of my dental condition. I realize that I am ultimately responsible for all cost of treatment. I understand the use of anesthetic agents embodies a certain risk. I authorize my insurance benefits to be paid to this Practice and/or my provider of record.

Signature Date