RUSTY M. ALBRECHT, D.D.S., Inc.
CHANDICE A. RICHARDS, D.D.S.
LUNDON R. ALBRECHT, D.D.S.

Date _____

PATIENT INFORMATION

Name (Last, First, Middle)_____ Preferred Name_____

Address _____ City _____State_____ Zip Code_____

Age _____ Birth Date _____ Sex □ M □ F Home Phone _____

Work Phone_____Cell Phone _____ Which is the best number to reach you at? _____

Do you give permission for our office to leave messages at this number? □ Y □ N SSN _____

Check Appropriate Space: □ Minor □ Widowed □ Single □ Married □ Separated □ Divorced

Patient's Employer _____Occupation_____ Position_____

Work Address _____ City _____ State _____ Zip _____

If student, name of school/college _____ Full-time □ Part-time □

Person to Contact in an Emergency _____ Phone _____ Relationship _____

If a Minor, Parent/Guardian's Name Filling Out Form _____ Relationship_____

Do you live at home with the patient? □ Y □ N If not, who does the patient reside with? _____ Relationship _____

Are you responsible for the patient's account? □ Y □ N If not, who is? _____ Relationship _____

DENTAL INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient _____

Birth Date _____ SSN _____ Primary Insurance Co. _____

Group # _____ ID#_____ Employer _____

Employer Address _____ City _____ State _____ Zip _____

Do you have additional dental insurance? □ Y □ N If yes, complete the following:

Name of Insured _____ Relationship to Patient _____

Birth Date _____ SSN _____ Employer _____

Employer Address _____ City _____ State _____ Zip _____

Primary Insurance Co. _____Group # _____ ID#_____

RESPONSIBLE PARTY

Name of Person Responsible for this Account _____ Relationship to Patient _____

****FILL OUT THE BELOW INFORMATION IF DIFFERENT FROM ABOVE:**

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ SSN _____

Birth Date _____Employer _____ Work Phone _____

Is this person currently a patient in our office? □ Y □ N

How did you hear about our office?

□ From a Friend □ Yellow Pages □ Mailing □ Radio Advertisement □ Newspaper Advertisement □ Other: _____

Whom may we thank for referring you? _____

PATIENT MEDICAL/DENTAL HISTORY

Patient's Name _____ **Date** _____

Physician _____ Date of Last Physical _____

Have you ever had any of the following? (Check boxes that apply)

☐ Artificial Heart Valves	☐ Epilepsy	☐ Pacemaker
☐ Heart Murmur	☐ Mental Illness	☐ Allergies
☐ Artificial Joints, Screws, etc.	☐ Asthma	☐ Back Problems
☐ Heart Disease/Heart Attack	☐ Bleeding Abnormally	☐ Hepatitis/Liver Disease
☐ Rheumatic Fever	☐ Chemical Dependency	☐ Sinus Problems
☐ Radiation or Cancer Therapy	☐ Tuberculosis	☐ Stroke
☐ HIV/AIDS	☐ Chest Pains/Angina	☐ Kidney Disease
☐ High Blood Pressure	☐ Diabetes	☐ Thyroid Trouble
☐ Low Blood Pressure	☐ Gastric By-Pass Surgery	☐ Mitral Valve Prolapse

Do you have or have you had any disease, condition, or problem not listed here? ☐ Y ☐ N _____

Have you ever responded adversely to medical or dental treatment? ☐ Y ☐ N _____

Do you smoke or use smokeless tobacco? ☐ Y ☐ N

Are you taking a blood thinner or anticoagulant? ☐ Y ☐ N

Are you taking any other medication(s) at this time? ☐ Y ☐ N Please list them: _____

_____

Have you had any allergic reactions to the following:

☐ Local Anesthetic	☐ Penicillin	☐ Sulfa Drugs
☐ Latex Rubber	☐ Aspirin	☐ Codeine
☐ Any Metals (i.e. nickel, mercury, etc.)	☐ Household Bleach	

☐ Other: _____

Is there anything else we should know about your medical history? _____

FOR WOMEN:

Do you suspect that you are pregnant? ☐ Y ☐ N Due Date _____ Doctor _____

Are you taking a bisphosphonate derivative? (i.e. hormone replacement therapy) ☐ Y ☐ N

	Yes	No
1. Is this your first dental visit?	☐	☐ Date of Last Exam _____
2. Have you had any unusual or unpleasant dental office experiences?	☐	☐
3. Do your gums bleed while brushing or flossing?	☐	☐
4. Are your teeth sensitive to hot, cold, or sweet food or liquids?	☐	☐
5. Are you experiencing any tooth pain?	☐	☐
6. Do you have any sores or lumps in or near your mouth?	☐	☐
7. Have you had any injuries to the face, mouth, or teeth?	☐	☐
8. Do you clench or grind your teeth?	☐	☐
9. Do you have frequent headaches?	☐	☐
10. Have you had any difficult extractions in the past?	☐	☐
11. Do you or have you had any oral piercings?	☐	☐
12. Have you been treated for gum disease?	☐	☐
13. Do you like your smile?	☐	☐
FOR CHILDREN:		
14. Do you have any oral habits such as thumbsucking or sleeping with a bottle at bed time?	☐	☐
15. Is your water fluoridated?	☐	☐

Why are you seeking dental care? _____

Please list any concerns that you may have concerning your dental health: _____

CERTIFICATION

To the best of my knowledge, the information I have provided on this form is complete and correct. I understand that reporting incomplete or inaccurate information can be dangerous to my health. I understand that I am solely responsible for any errors or omissions that I may have made in the completion of this form. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient or Parent/Personal Representative	Date	Print Name	Relationship
_____	_____	_____	_____