



FORSTER,
DAVIS
ROBERTS

W E L C O M E

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PATIENT INFORMATION

Name _____ Date _____

SS# _____

Address _____

City _____ State _____ Zip _____

Sex M F Age _____ Birthday _____

Married Widowed Single Minor Separated Divorced Partnered for _____ years

Parent / Guardian _____

Birthdate _____ SS# _____

Occupation _____ Employer _____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____ Spouse's Employer _____

Whom may we thank for referring you? _____

INSURANCE INFORMATION

Do you currently have dental insurance? Yes No Is patient covered by additional insurance? Yes No

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have health insurance coverage with _____ and assign directly to Dr. _____ all insurance

Name of Insurance Company

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. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date

Relationship to Patient

PHONE NUMBERS

Home (_____) _____ Work (_____) _____ Ext _____ Cell Phone (_____) _____

Spouse's Work (_____) _____ E-mail Address _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

DENTAL HISTORY

Reason for today's visit _____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental x-rays _____

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

Bad breath Yes No

Bleeding gums Yes No

Blisters on lips or mouth Yes No

Burning sensation on tongue Yes No

Chew on one side of mouth Yes No

Cigarette or tobacco use Yes No

Clicking or popping jaw Yes No

Dry mouth 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 of cheek biting Yes No

Loose teeth or broken fillings Yes No

Mouth pain, brushing Yes No

Orthodontic treatment Yes No

Pain around ear Yes No

Periodontal treatment Yes No

Sensitivity to cold Yes No

Sensitivity to heat Yes No

Sensitivity to sweets Yes No

Sensitivity when biting Yes No

Sores or growths in mouth Yes No

Are you happy with the appearance of your teeth? Yes No

If not, why? _____

How often do you floss? _____

How often do you brush? _____

HEALTH HISTORY

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? Yes No

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? Yes No

Date Treatment began: _____

HEALTH 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	Fainting or dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sleep Disorders/Apnea	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	CPAP Machine	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date _____		Hepatitis Type	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive daytime sleepiness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loud Snoring	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally, with extractions or surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stent Placement	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain	<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	Kidney Disease	<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	Liver Disease	<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	Low Blood Pressure	<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	Mitral Valve Prolapse	<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	Nervous Problems	<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	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor or growth on head or neck	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, persistant or bloody	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<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	Radiation Treatment	<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	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Wear Contact Lenses	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight loss, unexplained	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Have you ever been asked to take an antibiotic one hour before a routine dental visit? Yes No

Women:

Are you pregnant Yes No
Taking birth control pills Yes No Due Date _____ Are you nursing? Yes No

Note any disease, condition or problem not listed above _____

MEDICATIONS

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

Pharmacy Name _____ Phone (_____) _____

ALLERGIES

I am currently not aware of any allergies.

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

CONSENT FOR TREATMENT

- I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.
- Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
- I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any complications.

PATIENT or Legal Guardian _____ Date: _____

HISTORY REVIEW

Doctor's Signature _____ Date _____