Best Impressions
Family Dentistry

636 West Republic Road, Suite 120 • Springfield, Missouri 65807
phone: 417-882-3200
www.BestImpressionsDental.com

Name _____ Preferred Name _____
Last First Middle

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

❑ Male ❑ Female ❑ Minor SS# _____ Date of Birth _____

Patient's Employer (School) _____ Occupation _____

Employer Address _____

City _____ State _____ Zip _____

Spouse's Name _____ SS# _____

Spouse's Date of Birth _____ Spouse's Work Phone _____

Spouse's Employer _____

Please complete this section if the patient is a minor.

Father's Name _____ SS# _____ DOB _____

Father's Employer _____ Work Phone _____

Mother's Name _____ SS# _____ DOB _____

Mother's Employer _____ Work Phone _____

Insurance Company Name _____

Group # _____ Individual Policy# _____

Relationship to insured ❑ Self ❑ Spouse ❑ Covered Dependent

Insured's Name _____ Insured's SS# _____

Insured's DOB _____ Insured's Employer _____

Insured's Employer Address _____

Name of Person to contact in case of emergency _____

Phone Number _____ Relationship _____

Who may we thank for referring you to our office? _____

DENTAL HISTORY

Name and Location of Previous Dentist _____

Date of Last Visit _____ Reason for Last Visit _____

Do your gums bleed while brushing or flossing?	❑ Yes	❑ No	Do you have frequent headaches?	❑ Yes	❑ No
Are your teeth sensitive to hot or cold?	❑ Yes	❑ No	Do you clench or grind your teeth?	❑ Yes	❑ No
Are your teeth sensitive to sweet or sour things?	❑ Yes	❑ No	Do you bite you lips or cheeks?	❑ Yes	❑ No
Do you feel pain to any of your teeth?	❑ Yes	❑ No	Have you ever had difficult extractions?	❑ Yes	❑ No
Do you have any sores or lumps in or near your mouth?	❑ Yes	❑ No	Have you had any prolonged bleeding following extractions?	❑ Yes	❑ No
Have you had any head, neck or jaw injuries?	❑ Yes	❑ No	Have you ever had any orthodontic treatment?	❑ Yes	❑ No
Have you ever experienced any of the following Problems in your jaw?			Do you wear dentures or partials?	❑ Yes	❑ No
			If yes, date of placement_____		
Clicking	❑ Yes	❑ No	Have you ever received oral hygiene instructions?	❑ Yes	❑ No
Pain (joint, ear, side of face)	❑ Yes	❑ No	Do you like your smile?	❑ Yes	❑ No
Difficulty in opening or closing	❑ Yes	❑ No			
Difficulty in chewing	❑ Yes	❑ No			

MEDICAL HISTORY

Physician _____ Office Phone _____ Date of last exam _____

Are you under medical treatment? ❑ Yes ❑ No

Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? ❑ Yes ❑ No

If yes, please explain _____

_____

_____

Are you taking any medication(s) including Non-prescription medicine? ❑ Yes ❑ No

If yes, what _____

_____

Have you ever taken Fen-Phen/Redux? ❑ Yes ❑ No

Do you use tobacco? ❑ Yes ❑ No

Are you allergic to or have any reactions to the following?

Bleach	❑ Yes	❑ No
Codeine	❑ Yes	❑ No
Penicillin	❑ Yes	❑ No
Other Antibiotics	❑ Yes	❑ No
Sulfa Drugs	❑ Yes	❑ No
Iodine	❑ Yes	❑ No
Aspirin	❑ Yes	❑ No
Any Metals (e.g. nickel)	❑ Yes	❑ No
Latex Rubber	❑ Yes	❑ No

Other (please list) _____

Women Only:

Are you pregnant or think you may be pregnant?	❑ Yes	❑ No
Are you nursing?	❑ Yes	❑ No
Are you taking oral contraceptives?	❑ Yes	❑ No

Do you have or have had any of the following?

High Blood Pressure	❑ Yes	❑ No	Heart Disease	❑ Yes	❑ No
Heart Attack	❑ Yes	❑ No	Cardiac Pacemaker	❑ Yes	❑ No
Rheumatic Fever	❑ Yes	❑ No	Heart Murmur	❑ Yes	❑ No
Swollen Ankles	❑ Yes	❑ No	Angina	❑ Yes	❑ No
Fainting/ Seizures	❑ Yes	❑ No	Frequently Tired	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	Anemia	❑ Yes	❑ No
Low Blood Pressure	❑ Yes	❑ No	Emphysema	❑ Yes	❑ No
Epilepsy/ Convulsions	❑ Yes	❑ No	Cancer	❑ Yes	❑ No
Leukemia	❑ Yes	❑ No	Arthritis	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No	Joint Replacement or Implant	❑ Yes	❑ No
Kidney Disease	❑ Yes	❑ No	Hepatitis/ Jaundice	❑ Yes	❑ No
AIDS or HIV infection	❑ Yes	❑ No	Sexually Transmitted Disease	❑ Yes	❑ No
Thyroid Problem	❑ Yes	❑ No	Stomach Trouble/ Ulcers	❑ Yes	❑ No
Chest Pains	❑ Yes	❑ No	Easily Winded	❑ Yes	❑ No
Stroke	❑ Yes	❑ No	Hay Fever/ Allergies	❑ Yes	❑ No
Tuberculosis	❑ Yes	❑ No	Radiation Therapy	❑ Yes	❑ No
Glaucoma	❑ Yes	❑ No	Recent Weight Loss	❑ Yes	❑ No
Liver Disease	❑ Yes	❑ No	Heart Trouble	❑ Yes	❑ No
Respiratory Problems	❑ Yes	❑ No	Mitral Valve Prolapse	❑ Yes	❑ No

Other _____

Consent for Treatment & Payment Policy Agreement

I certify that I have completed this form fully and completely. The above information is accurate to the best of my knowledge, and I understand that providing false information can be dangerous to my health. I grant authority to the Dentist and staff to perform the necessary exam, x-rays, and subsequent treatment needed to restore and maintain my dental health or the health of my dependent.

I have had the opportunity to read and have a copy of this offices Notice of Privacy Practices. I Authorize the Dentist to release any information including the diagnosis and the records of any treatment or exam rendered to my or my dependent during the period of such dental care to third party payors and/or other health practitioners as needed for my treatment or payment thereof.

I authorize and request my insurance company to pay benefits on my behalf directly to the dentist. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents including any collection costs.

Signature _____ Date _____