COPPER CANYON
DENTAL
MITCHELL LEPETICH, DMD
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MEDICAL AND DENTAL HISTORY

Patient Information *DATE* ___/____/____

Name: _____

Address: _____

_____

Date of Birth: _____SS#: _____

□ Single □ Married □ Divorced □ Child □ Widowed

Employer/School: _____

How did you hear about Copper Canyon Dental?

□ Referral _____

□ Postcard □ Google □ Email □ Website □ Building Sign

□ Insurance Company □ Other _____

Primary Dental Insurance

Subscriber Name: _____

Relationship to Patient: _____

Date of Birth: _____

SS/ID# (Required) _____

Address (if different from Patient): _____

_____

Subscriber's Employer: _____

Insurance Company: _____

Group #: _____

Secondary Dental Insurance (if applicable)

Subscriber Name: _____

Relationship to Patient: _____

Date of Birth: _____

SS/ID# (Required) _____

Subscriber's Employer: _____

Insurance Company: _____

Group #: _____

Insurance Authorization

For my convenience, Copper Canyon Dental may release my information to my insurance company and receive payment directly from them. I hereby authorize payment directly to Copper Canyon Dental of the insurance benefits otherwise payable to me. Treatment plans may change, and I am responsible for work actually done. I understand that I am financially responsible for all charges whether or not paid by insurance.

INITIAL: _____

Notice of Privacy Policies

I have had full opportunity to read and consider the contents of the *Notice of Privacy Policies*. I understand that I am giving permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke that permission.

INITIAL: _____

Contact Information

Home Phone: _____ Cell: _____ Work: _____

Email: _____ What is your preferred method of contact? _____

EMERGENCY CONTACT INFORMATION

Name: _____ Phone Number: _____ Place of employment: _____

FOR OFFICE USE: MED Hx Reviewed _____ *DATE*_____

Dental History

Reason for today's visit: _____

Is there anything you would like to change about your smile? _____

Former Dentist: _____ City/State: _____

Why did you leave your last dentist? _____ Date of last dental visit:_____

How often do you floss?:_____ How often do you brush?_____

Please check all that apply: □ **None apply**

- □ Bad Breath
- □ Bleeding gums
- □ Blisters on lips or mouth
- □ Burning sensation on tongue
- □ Chew on one side of mouth
- □ Cheek biting
- □ Cigarette/pipe/cigar smoking
  Frequency: _____
- □ Clicking or popping jaw
- □ Dry mouth
- □ Fingernail biting
- □ Food collection between teeth
- □ Foreign objects
- □ Grinding teeth
- □ Gums swollen or tender
- □ Jaw pain / tiredness
- □ Lip or cheek biting
- □ Loose teeth/broken fillings
- □ Mouth breathing
- □ Mouth pain, brushing
- □ Orthodontic treatment
- □ Pain around ear
- □ Periodontal treatment / deep scaling
- □ Sensitivity to cold
- □ Sensitivity to heat
- □ Sensitivity to sweets
- □ Sensitivity when biting
- □ Sores / Growths in mouth
- □ Dental Anxiety
- □ Other: _____

Health History

Physician's Name : _____ Date of last visit: _____

Have you ever taken any medications containing bisphosphonates? This includes brands such as: Fosamax, Actonel, Didronel, Boniva, Aredia and Zometa . □ Yes □ No

Please check all that apply: □ **None apply**

- □ AIDS/HIV
- □ Anemia
- □ Arthritis, Rheumatism
- □ Artificial Heart Valves
- □ Artificial Joints
- □ Asthma
- □ Back Problems
- □ Bleeding abnormally, with extractions
- □ Blood Disease
- □ Cancer
- □ Chemical Dependency
- □ Chemotherapy
- □ Circulatory Problems
- □ Congenital Heart Lesions
- □ Cortisone Treatments
- □ Cough, persistent/bloody
- □ Diabetes
- □ Dizziness
- □ Emphysema
- □ Epilepsy
- □ Fainting
- □ Glaucoma
- □ Headaches
- □ Heart Murmur
- □ Heart Problems
- □ Hepatitis Type _____
- □ Herpes
- □ High Blood Pressure
- □ Jaundice
- □ Jaw Pain
- □ Kidney Disease
- □ Liver Disease
- □ Low Blood Pressure
- □ Mitral Valve Prolapse
- □ Nervous Problems
- □ Pacemaker
- □ Psychiatric Care
- □ Radiation Treatment
- □ Respiratory Disease
- □ Rheumatic Fever
- □ Scarlet Fever
- □ Shortness of Breath
- □ Sinus Trouble
- □ Skin Rash
- □ Special Diet
- □ Stroke
- □ Swollen Feet/Ankles
- □ Swollen Neck Glands
- □ Thyroid Problems
- □ Tonsillitis
- □ Tuberculosis
- □ Tumor or Growth on Head or Neck
- □ Ulcer
- □ Venereal Disease
- □ Weight Loss/Gain
- □ Taking Birth Control Pills
- □ Pregnant (Due Date _____)
- □ Nursing
- □ Other: _____
  _____

Medications

List any medications you are currently taking and the reason:

_____

_____

_____

Allergies

- □ Asprin
- □ Codeine
- □ Dental Anesthetics
- □ Erythromycin
- □ Latex
- □ Metals
- □ Penicillin
- □ Sulfa
- □ Tetracycline
- □ Other _____

I certify to the accuracy of the above statements regarding my medical and dental history. I authorize and give consent to perform dental services agreed between Copper Canyon Dental and patient (and/or parent or guardian) which is necessary or advisable, including the use of anesthesia and other medication as indicated.

Signature (Parent/Guardian if under 18) | Printed name | Date