

Dr. Robert J. Van Dyke
8670 W. Cheyenne Ave, Ste 205
Las Vegas, NV 89129
(702)360-3030

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(800) 243-4675

welcome

Date _____

Patient's Name _____ Date of Birth _____ Male Female
Last First Initial

If Child: Parent's Name _____

How do you wish to be addressed _____
Single Married Separated Divorced Widowed Minor

Residence - Street _____

City _____ State _____ Zip _____

Business Address _____

Telephone: Res. _____ Bus. _____

Fax _____ Cell Phone # _____

eMail _____

Patient/Parent Employed By _____

Present Position _____

How Long Held _____

Spouse/Parent Name _____

Spouse Employed By _____

Present Position _____

How Long Held _____

Who is Responsible for this account _____

Drivers License No. _____

Method of Payment: Insurance Cash Credit Card

Purpose of Call _____

Other Family Members in this Practice _____

Whom may we thank for this referral _____

Patient/parent Social Security No. _____

Spouse/Parent Social Security No. _____

Someone to notify in case of emergency not living with you _____

DENTAL INSURANCE
1ST COVERAGE

Employee Name _____ Date of Birth _____

Employer Name _____ Yrs. _____

Name of Insurance Co. _____

Address _____

Telephone _____

Program or policy # _____

Social Security No. _____

Union Local or Group _____

DENTAL INSURANCE
2ND COVERAGE

Employee Name _____ Date of Birth _____

Employer Name _____ Yrs. _____

Name of Insurance Co. _____

Address _____

Telephone _____

Program or policy # _____

Social Security No. _____

Union Local or Group _____

RELEASE:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.

I attest to the accuracy of the information on this page.

PATIENTS OR GUARDIAN'S SIGNATURE

DATE _____

welcome

Patient's Name _____ Last _____ First _____ Initial _____ Date of Birth _____

1. Purpose of initial visit _____
2. Are you aware of a problem? _____
3. How long since your last dental visit? _____
4. What was done at that time? _____
5. Previous dentist's name _____
Address: _____ Tel. _____
6. When was the last time your teeth were cleaned? _____

COMMENTS

- CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER, PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.
7. Have you made regular visits?YES NO
How often: _____
 8. Were dental x-rays taken?YES NO
 9. Have you lost any teeth or have any teeth been removed?YES NO
Why? _____
 10. Have they been replaced?YES NO
 11. How have they been replaced?
a. Fixed bridge _____ Age _____
b. Removable bridge _____ Age _____
c. Denture _____ Age _____
 12. Are you unhappy with the replacement?YES NO
If yes, explain _____
 13. Would you like to know about permanent replacements?YES NO
 14. Have you ever had any problems or complications with previous dental treatment?YES NO
If yes, explain: _____
 15. Do you clench or grind your teeth?YES NO
 16. Does your jaw click or pop?YES NO
 17. Have you experienced any pain or soreness in the muscles or your face or around your ear?YES NO
 18. Do you have frequent headaches, neckaches or shoulder aches?YES NO
 19. Does food get caught in your teeth?YES NO
 20. Are any of your teeth sensitive to: Hot? Cold? Sweets? Pressure?
 21. Do your gums bleed or hurt?YES NO
When? _____
 22. How often do you brush your teeth? _____ When? _____
 23. Do you use dental floss?YES NO
How often? _____
 24. Are any of your teeth loose, tipped, shifted or chipped?YES NO
 25. Are you unhappy with the appearance of your teeth?YES NO
 26. How do you feel about your teeth in general? _____
 27. Do you feel your breath is offensive at times?YES NO
 28. Have you ever had gum treatment or surgery?YES NO
What? _____
Where? _____
When? _____
 29. Have you had any orthodontic work? _____
 30. Have you had any unpleasant dental experiences or is there anything about dentistry that you ..
strongly dislike? _____
 31. Do you have any questions or concerns?YES NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

ANEST.

MED. ALERT

DENTAL HISTORY

welcome

Patient's Name _____
 Last _____ First _____ Initial _____ Date of Birth _____

CIRCLE THE APPROPRIATE ANSWER, IF YOU DON'T KNOW THE CORRECT ANSWER PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION

COMMENTS

1. Physician's Name _____
 Address _____
2. Are you under a physician's care?YES NO
 Since when _____ Why _____
3. When was your last complete physical exam? _____
4. Are you taking any medication or substances?YES NO
 (If yes, please list medications in comments section or on the back of this form.)
5. Do you routinely take health related substances?YES NO
6. Are you allergic to any medications or substances? (please list)YES NO
7. Do you have any other allergies or hives?YES NO
8. Do you have any problems with penicillin, antibiotics, anesthetics
 or other medications?YES NO
9. Are you sensitive to any metals or latex?YES NO
10. Are you pregnant or suspect you may be?YES NO
11. Do you use any birth control medications?YES NO
12. Have you ever been treated for or been told you might have heart disease?YES NO
13. Do you have a pacemaker or an artificial heart valve implant?YES NO
14. Have you ever had rheumatic fever?YES NO
15. Are you aware of any heart murmurs?YES NO
16. Do you have high or low blood pressure? (please circle)YES NO
17. Have you ever had a serious illness or major surgery?YES NO
 If so, explain _____
18. Have you ever had radiation treatment, chemo treatment for tumor,
 growth or other condition?YES NO
19. Do you have inflammatory diseases, such as arthritis or rheumatism?YES NO
20. Do you have any artificial joints/prosthesis?YES NO
21. Do you have any blood disorders, such as anemia, leukemia, etc?YES NO
22. Have you ever bled excessively after being cut or injured?YES NO
23. Do you have any stomach problems?YES NO
24. Do you have any kidney problems?YES NO
25. Do you have any liver problems?YES NO
26. Are you diabetic?YES NO
27. Do you have fainting or dizzy spells?YES NO
28. Do you have asthma?YES NO
29. Do you have epilepsy or seizure disorders?YES NO
30. Do you or have you had venereal disease?YES NO
31. Have you tested HIV positive?YES NO
32. Do you have AIDS?YES NO
33. Have you had or do you test positive for hepatitis?YES NO
34. Do you or have you had T.B.?YES NO
35. Do you smoke, chew, use snuff or any other forms of tobacco?YES NO
36. Do you consume alcoholic beverages?YES NO
37. Do you habitually use controlled substances?YES NO
38. Have you had psychiatric treatment?YES NO
39. Have you taken any prescription drugs fenfluramine, fenfluramine combined with
 phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products?YES NO
40. Do you have any disease condition, or problem not listed? If so, explain _____

41. Is there anything else we should know about your health that we have not covered in this form? _____
42. Would you like to speak to the Doctor privately about any problem?YES NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____
 DENTIST'S SIGNATURE _____ DATE _____

ANEST.

MED. ALERT

MEDICAL HISTORY

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SECTION A: The Patient.

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: Acknowledgement of Receipt of Privacy Practices Notice.

I, _____, acknowledge that I have received a Notice of Privacy Practices from the above-named practice.

Signature: _____ Date: _____

If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

SECTION C: Good Faith Effort to Obtain Acknowledgement of Receipt.

Describe your good faith effort to obtain the individual's signature on this form: _____

Describe the reason why the individual would not sign this form: _____

SIGNATURE.

I attest that the above information is correct.

Signature: _____ Date: _____

Print name: _____ Title: _____

Include this acknowledgement of receipt in the individual's records.

**ACKNOWLEDGEMENT OF RECEIPT OF
PRIVACY PRACTICES NOTICE**