Nebraska Family Dentistry
ALL LOCATIONS
Changing Dentistry, Changing Lives

Patient Information

Name_____ SS#_____

Address_____ Email_____

City_____State_____Zip_____ Home Phone_____

DOB_____ Sex: M O F O Cell Phone_____

O Single O Married O Divorced O Other Contact Preference? O Phone O Text O Email

Employer_____ Employer Phone_____

Spouse's Name_____ Spouse's Employer_____

How did you hear about our office?_____

Dental Insurance

Name of Policyholder_____

Policyholder's DOB_____ Policyholder's SS#_____

Policyholder's Employer_____ Relationship to Patient_____

Policy ID Number _____ Group Number _____

What is your main concern for today's exam? _____

Handle My Dental Needs With Care

	Yes	No
Are you afraid of the dentist?	O	O
Are you afraid of shots?	O	O
Do you like your smile?	O	O
Do your gums bleed when you brush or floss?	O	O
Are your teeth sensitive to cold, hot, or pressure?	O	O
Do you drink soda-pop?	O	O
Do you floss on a daily basis?	O	O
Does food or floss catch between your teeth?	O	O
Is your mouth dry?	O	O
Have you had any periodontal (gum) treatments?	O	O
Have you ever had orthodontic (braces) treatment?	O	O
Have you had any problems associated with previous dental treatment?	O	O
Experiencing any dental discomfort?	O	O
Do you have earaches or neck pains?	O	O
Do you have any clicking or discomfort in your jaw?	O	O
Do you grind your teeth?	O	O

	Yes	No
Do you have any sores or ulcers in your mouth?	O	O
Do you wear dentures or partials?	O	O
Have you ever had a serious injury to your head or mouth?	O	O
Do you gag easily?	O	O

When was your last dental visit? _____

□□□ I would like to find out more about: □□□

How to get my teeth whiter?	O	O
How to fix crowding between teeth?	O	O
How to fix spacing between teeth?	O	O
Options for replacing missing teeth?	O	O
How to replace old crowns/fillings?	O	O
Should I replace my old mercury/metal fillings?	O	O
How to avoid orthodontics and get the perfect smile?	O	O
How to get rid of long/short teeth?	O	O
How to get rid of a gummy smile?	O	O

Physician's Name_____ Date of last visit_____

Preferred Pharmacy: _____ Location _____

*Please indicate if you **have** or **had** any of the following:

- ○ AIDS /HIV
- ○ Allergy
- ○ Anemia
- ○ Artificial Heart Valve
- ○ Artificial Joint
- ○ Asthma
- ○ Bleeding Problems
- ○ Blood Transfusion
- ○ Cancer
- ○ Chemotherapy
- ○ Cold Sores
- ○ Diabetes
- ○ Emphysema
- ○ Epilepsy or convulsions
- ○ Fainting Spells/Seizures
- ○ Family History of Hyperthermia
- ○ Fever Blisters
- ○ Glaucoma
- ○ Heart Defect or Murmur
- ○ High Blood Pressure
- ○ Hepatitis A (infectious)
- ○ Hepatitis B (serum)
- ○ Herpes
- ○ Heart Trouble / Attack
- ○ Immune System
- ○ Disorder Kidney Trouble
- ○ Prolapsed Mitral Valve
- ○ Radiation Treatment
- ○ Rheumatic Heart
- ○ Disease Pacemaker
- ○ Sinus Trouble
- ○ Stroke
- ○ Taken Cortisone in Past Year Tuberculosis
- ○ Ulcers

Do you smoke? Yes ○ No ○ Have you taken bisphosphonate drugs? Yes ○ No ○

Other:_____

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

_____

_____

_____

Allergies:

- ○Aspirin ○ Codeine
- ○Local Anesthetics ○ Penicillin
- ○Acrylic ○ Latex / Rubber
- ○Sulfa Drugs ○ Metals
- ○Other allergies: _____

Women:	**Yes**	**No**
Are you pregnant?	○	○
Due Date: _____		
Are you nursing?	○	○
Taking birth control?	○	○

If so, is there anything else we should know?

_____

***Please list any other person(s) that have permission to access your records and account information:*

_____

*** Please let us know if you would like a copy of Notice of Privacy Practices HIPAA that is offered to all our patients*

We are pleased to welcome you to our practice!_____

(Signature of patient or parent / guardian)