1234567891011121314151617181 9
D. Hamilton Sims, DMD
2101 SE 39th Ave.
Portland, Oregon 97214
503-234-6148

welcome

Beautiful Healthy Smiles

1 About You

Today's Date: 1234567891/1234567891/1234567891 File # _____

Patient Name: 1234567891011121314151617181 9 1234567891011121314151617181 9 1234567891
Last First MI

What you prefer to be called: 1234567891011121314151617181 9

Birthdate: 1234567891/1234567/1234567891 Age: 1234567891 SS# 1234567891-1234567891-12345678910111

Mailing Address: 1234567891011121314151617181 9

1234567891011121314151617181 9 1234567891011121314151617181 9 1234567891011121314151
City State Zip

Home # 1234567891011121314151617181 9 Work # 1234567891011121314151617181 9

Cell # 1234567891011121314151617181 9 Email Address: 1234567891011121314151617181 9

Referred By: 1234567891011121314151617181 9

Employer: 1234567891011121314151617181 9

Employer Address: 1234567891011121314151617181 9

1234567891011121314151617181 9 1234567891011121314151617181 9 123456789101112131
City State Zip

Status: ☒Minor ☒Single ☒Married ☒Partner

Spouse/Partner Name: 1234567891011121314151617181 9

Do you have children? ☒Yes ☒No How Many? 12345678910111213141516171819

2 Insurance Information

Primary Dental Insurance

Insured person's name: 1234567891011121314151617181 9

Relation: ☒Self ☒Spouse/Partner ☒Parent/Guardian

Insured Person's Employer: 1234567891011121314151617181 9

Insured's SS # 1234567891011 - 1234567891011 - 12345678910111213

Dental Insurance Co. 1234567891011121314151617181 9 Phone# 123456789101112131415161

Address: 1234567891011121314151617181 9 1234567891011121314151617181 9 1234567891011121314151617181 9
City State Zip

Insurance ID # 1234567891011121314151617181 9 Group # 1234567891011121314151617181 9

Secondary Dental Insurance

Insured person's name: 1234567891011121314151617181 9

Relation: ☒Self ☒Spouse/Partner ☒Parent/Guardian

Insured Person's Employer: 1234567891011121314151617181 9

Insured's SS # 1234567891011 - 1234567891011 - 12345678910111213

Dental Insurance Co. 1234567891011121314151617181 9 Phone# 123456789101112131415161

Address: 1234567891011121314151617181 9 1234567891011121314151617181 9 1234567891011121314151617181 9
City State Zip

3 Account Information

Person responsible for account

Name: 1234567891011121314151617181 9

Relation: ☒Self ☒Spouse/Partner ☒Parent/Guardian

Billing Address: 1234567891011121314151617181 9

1234567891011121314151617181 9 1234567891011121314151617181 9 1234567891011121314151617
City State Zip

Home # 1234567891 Work # 1234567891

SS # 1234567891011 - 1234567891 - 12345678910111 Drivers License# 1234567891011121314151617

Payment Method: ☒Cash ☒Check ☒MC/Visa

_____ I hereby authorize assignment of my insurance rights and
Initials
benefits directly to the provider for services rendered. I fully understand that I am solely responsible for any balance not paid by my insurance company.

4 In Event of Emergency

Whom should we contact? 1234567891011121314151617181 9 Relation: 1234567891011121314151617181 9

Address: 1234567891011121314151617181 9

Home # 1234567891011121314151617181 9 Work # 1234567891011121314151617181 9 Cell # 123456789101112131415161

Who is your medical doctor? 1234567891011121314151617181 9 Phone# 1234567891011121314151617181 9

Please Continue on Back

5 Dental Information

Patient Name: 1234567891011121314151617181 9 **Today's Date:** 1234567891011121314151617181 9

Reason for today's visit: ☒ Exam ☒ Emergency ☒ Consultation **Are you in pain?** ☒ Yes ☒ No **How Long?** 1234567891011121314151617181 9

Please indicate any of the following problems:

☒Discomfort, clicking or popping in jaw	☒Lost/Broken Filling(s)	☒Stained teeth
☒Red, swollen or bleeding gums	☒Teeth Grinding	☒Locking Jaw
☒Sensitive tooth, teeth or gums	☒Ringing in Ears	☒Bad breath
☒Blisters/Sores in or around the mouth	☒Broken/Chipped tooth	☒Other 1234567891011121314151617181 9

Last Dental Exam: 1234567891011121314151617181 9 Last Dental X-Rays: 1234567891011121314151617181 Previous Dentist: 1234567891011121314151617181 9 Phone: 1234567891011121314151617181

Do you require Pre-medication? ☒Yes ☒No ☒Don't Know

Times a day you brush? 12345678910 Times a week you floss? 12345678910 Type of toothbrush you use? ☒Soft ☒Medium ☒Hard

How would you rate your smile ☒ ☒ ☒ ☒ ☒ ☒ ☒ ☒ ☒ ☒ Would you like to change anything? 1234567891011121314151617181 9

6 Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health-problems that you may have or medication that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	☒Yes ☒No	Are you on a special diet?	☒Yes ☒No
Have you ever been hospitalized or had a major operation?	☒Yes ☒No	Do you use Tobacco?	☒Yes ☒No
Have you ever had a head or neck injury?	☒Yes ☒No	If yes, how long? 1234567891011121314151617	How much per day? 1234567891011121314151617
Are you taking any medications, pills, or drugs?	☒Yes ☒No		

Please list all medications 1234567891011121314151617181 9

Are you allergic to the following? ☒Aspirin ☒Penicillin ☒Acrylic ☒Metal ☒Latex ☒Local Anesthetics ☒Other 1234567891011121314151617181 9

Women: Are you: ☒Pregnant / trying to get pregnant? ☒Nursing ☒Taking oral contraceptives?

Do currently have or have you ever had any of the following? Please ☑ all that apply

☒ AIDS/HIV Positive	☒ Chest Pains	☒ Frequent Headaches	☒ Irregular Heartbeat	☒ Scarlet Fever
☒ Alzheimer's Disease	☒ Cold Sores/Fever Blisters	☒ Genital Herpes	☒ Kidney Problems	☒ Shingles
☒ Anaphylaxis	☒ Congenital heart Disorder	☒ Glaucoma	☒ Leukemia	☒ Sickle Cell Disease
☒ Anemia	☒ Convulsions	☒ Hay Fever	☒ Liver Disease	☒ Sinus Trouble
☒ Angina	☒ Cortisone Medicine	☒ Heart Attack/Failure*	☒ Low Blood Pressure	☒ Spina Bifida
☒ Arthritis	☒ Diabetes	☒ Heart Murmur*	☒ Lung Disease	☒ Stomach/Intestinal Disease
☒ Artificial Heart Valve*	☒ Drug Addiction	☒ Heart Pace Maker*	☒ Mitral Valve Prolaspe*	☒ Stroke
☒ Artificial joint*	☒ Easily Winded	☒ Heart Trouble/Disease	☒ Pain in Jaw Joints	☒ Swelling of Limbs
☒ Asthma	☒ Emphysema	☒ Hemophilia	☒ Parathyroid Disease	☒ Thyroid Disease
☒ Blood Disease	☒ Epilepsy or Seizures	☒ Hepatitis A	☒ Psychiatric Care	☒ Tonsillitis
☒ Blood Transfusion	☒ Excessive Bleeding	☒ Hepatitis B or C	☒ Radiation Treatments	☒ Tuberculosis
☒ Breathing Problem	☒ Excessive Thirst	☒ Herpes	☒ Recent Weight Loss	☒ Tumors or Growths
☒ Bruise easily	☒ Fainting Spells/Dizziness	☒ High Blood Pressure	☒ Renal Dialysis	☒ Ulcers
☒ Cancer_____	☒ Frequent Cough	☒ Hives or Rash	☒ Rheumatic Fever*	☒ Venereal Disease

Have you ever had any serious illness not listed above? ☒ Yes ☒ No If yes please list: 1234567891011121314151617181 9

May require medication

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

× _____ _____

Signature of patient, parent or guardian Date

Medical Updates

I have read my Medical History and confirm that it adequately states past and present conditions.

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____