



Adult's Information Form

Please fill out these forms completely. Return them to our office or fax them to 208-375-7790
The better we communicate, the better we can care for you.

ABOUT YOU

Date _____

Name _____
Last First Mr. Mrs. Ms. Other

I prefer to be called: _____

Home Address _____
Street
City State Zip

Birth Date ____/____/____ Age _____

SS# _____._____._____ DL# _____

Home Tel # _____ Work # _____

Your Employer _____

Occupation _____

Whom may we thank for referring you _____

Other family members or friends seen by us _____

Special interests or Hobbies _____

SPOUSE INFORMATION

Spouse's Name _____

SS# _____._____._____

Employer _____

Occupation _____

Work # _____

Is someone besides yourself responsible for payment
of this account? YES NO

If yes, who? _____

Address _____

Phone # _____

DENTAL INSURANCE

**If you have dental insurance and want us to file it for
you please provide the following information.**

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone # _____

Insured's Name _____

Relation _____

Insured's Birthday ____/____/____

Insured's SS# _____._____._____

Insured's Employer _____

Do you have any other
Dental Insurance Coverage? YES NO

This coverage is through:

Spouse Parent Other _____

Their name _____

Their Employer's Name _____

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone # _____

Group # (Plan Local Policy #) _____

Insured's Name _____ Relation _____

Insured's Birthday ____/____/____

Insured's SS# _____._____._____

**In the event of an emergency is there someone who
lives near you that we could contact?**

Name _____

Relationship _____

Work # _____

Home # _____

YOUR MEDICAL HISTORY

Do you have a personal physician? YES NO

Physician's Name _____

Physician's Phone _____

The approximate date of your last doctor's visit ____/____/____

Do you have any health problems? _____

Are you currently under the care of a physician? YES NO

If yes, please explain _____

Do you smoke or use tobacco in any form? YES NO

Are you currently taking any medications? YES NO

If yes, please list:

For Women:

Are you pregnant? Yes No Week _____

Are you nursing? Yes No

Are you taking birth control pills? Yes No

Have you ever had the following diseases or medical problems?

Y N Heart Attack/Stroke

Y N Asthma

Y N Heart Murmur/Rheumatic Fever

Y N Sinus Problems

Y N Heart Surgery/Pace Maker

Y N Hepatitis

Y N Kidney or Thyroid Problem

Y N Tuberculosis

Y N Cancer/Chemotherapy

Y N X-Ray Therapy

Y N High or Low Blood Pressure

Y N HIV+/AIDS

Y N Prolonged Bleeding

Y N Diabetes

Y N Epilepsy Seizures/Fainting Spells

Y N Drug/Alcohol Abuse

Y N Joint Replacements

Do you have any medical conditions not listed above? YES NO

Please list _____

Are you allergic to any of the following drugs?

Penicillin _____ Aspirin _____

Erythromycin _____ Codeine _____

Dental Anesthetics _____

Are you allergic to any other drugs? YES NO

Please List _____

YOUR DENTAL HISTORY

Please List Why have you come to the dentist today? _____

The approximate date of your last visit ____/____/____

Are you currently in pain YES NO

Have you had an unfavorable experience with previous dental treatment? YES NO

If yes, please describe _____

Do local anesthetics work well for you? YES NO

Do you need additional help such as Nitrous Oxide? YES NO

Have you used Nitrous Oxide before? YES NO

Do your gums bleed easily or feel tender or irritated? YES NO

Do you like your smile? YES NO

If no, what would you like to change? _____

Are you apprehensive about dental treatment? YES NO

Are you interested in preventative care? YES NO

You will automatically be placed on a regular maintenance program unless you request otherwise.

Do you have any suggestions which you feel would be helpful for treating you? _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

Signature _____

Date _____

Initial Updates _____