



Welcome to
Cheyenne Mountain Dental Center
"Your Healthy Mouth Connection"

1803 B Street
Colorado Springs, CO 80906
719-576-1730 or 877-433-9634 (toll free)

Thank you for choosing us for your dental needs. Please complete these forms. If you have any questions or concerns, do not hesitate to call us.

Referral Source _____

PATIENT INFORMATION

First Name _____ Last Name _____ Middle Initial ____

Patient is Policy Holder Responsible Party Preferred Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Ext _____ Cell Phone _____

Sex Male Female Marital Status Married Single Divorced Separated Widowed

Date of Birth _____ Age _____ Soc Sec _____ Drivers Lic _____

E-Mail _____

Emergency Contact _____

RESPONSIBLE PARTY

First Name _____ Last Name _____ Middle Initial ____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Ext _____ Cell Phone _____

Date of Birth _____ Age _____ Soc Sec _____ Drivers Lic _____

Responsible Party is also a Policy Holder for Patient Primary Insurance Policy Holder Secondary Insurance Policy Holder

PRIMARY INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient Self Spouse Child Other

Insured Soc Sec _____ Insured Date of Birth _____

Employer _____ Insurance Company _____

SECONDARY INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient Self Spouse Child Other

Insured Soc Sec _____ Insured Date of Birth _____

Employer _____ Insurance Company _____

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 question.

- Are you under a physician's care now? Yes No If yes, please explain _____
- Have you ever been hospitalized or had a major operation? Yes No If yes, please explain _____
- Have you ever had a serious head or neck injury? Yes No If yes, please explain _____
- Are you taking any medications, pills or drugs? Yes No If yes, please explain _____
- Do you use tobacco? Yes No If yes, please explain _____
- Do you use controlled substances? Yes No If yes, please explain _____

Women: are you Pregnant/Trying to get Pregnant? Nursing Taking Oral Contraceptives

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Local Anesthetics Foods

Other If yes, please explain:

Do you have, or have you had any of the following?

1. <input type="checkbox"/> AIDS/HIV Positive	18. <input type="checkbox"/> Cold Sores/Fever Blisters	35. <input type="checkbox"/> Fainting Spells or Dizziness	52. <input type="checkbox"/> Hives or Rash	69. <input type="checkbox"/> Rheumatism
2. <input type="checkbox"/> Alzheimer's Disease	19. <input type="checkbox"/> Congenital Heart Disorder	36. <input type="checkbox"/> Frequent Cough	53. <input type="checkbox"/> Hypoglycemia	70. <input type="checkbox"/> Scarlet Fever
3. <input type="checkbox"/> Anaphylaxis	20. <input type="checkbox"/> Contact Lenses	37. <input type="checkbox"/> Frequent Diarrhea	54. <input type="checkbox"/> Irregular Heartbeat	71. <input type="checkbox"/> Shingles
4. <input type="checkbox"/> Anemia	21. <input type="checkbox"/> Constipation	38. <input type="checkbox"/> Frequent Headaches	55. <input type="checkbox"/> Kidney/Bladder Problems	72. <input type="checkbox"/> Sickle Cell Disease
5. <input type="checkbox"/> Angina	22. <input type="checkbox"/> Convulsion	39. <input type="checkbox"/> Frequent Urination	56. <input type="checkbox"/> Leukemia	73. <input type="checkbox"/> Sinus Trouble
6. <input type="checkbox"/> Arthritis/Gout	23. <input type="checkbox"/> Cortisone Medicine	40. <input type="checkbox"/> Genital Herpes	57. <input type="checkbox"/> Liver Disease	74. <input type="checkbox"/> Skin Disease
7. <input type="checkbox"/> Artificial Heart Valve	24. <input type="checkbox"/> Diabetes	41. <input type="checkbox"/> Glaucoma	58. <input type="checkbox"/> Low Blood Pressure	75. <input type="checkbox"/> Spina Bifida
8. <input type="checkbox"/> Artificial Joint	25. <input type="checkbox"/> Difficulty Swallowing	42. <input type="checkbox"/> Hay fever	59. <input type="checkbox"/> Lung Disease	76. <input type="checkbox"/> Stomach/Intestinal Disease
9. <input type="checkbox"/> Asthma	26. <input type="checkbox"/> Difficulty Urinating	43. <input type="checkbox"/> Heart Attach/Failure	60. <input type="checkbox"/> Mitral Valve Prolapse	77. <input type="checkbox"/> Stroke
10. <input type="checkbox"/> Blood Disease	27. <input type="checkbox"/> Drug Addiction	44. <input type="checkbox"/> Heart Murmur	61. <input type="checkbox"/> Pain in Jaw Joints	78. <input type="checkbox"/> Swelling of Limbs/Joints
11. <input type="checkbox"/> Blood Transfusion	28. <input type="checkbox"/> Dry Mouth	45. <input type="checkbox"/> Heart Pace Maker	62. <input type="checkbox"/> Parathyroid Disease	79. <input type="checkbox"/> Thyroid Disease
12. <input type="checkbox"/> Blurred Vision	29. <input type="checkbox"/> Easily Winded	46. <input type="checkbox"/> Heart Trouble/Disease	63. <input type="checkbox"/> Persistent Cough	80. <input type="checkbox"/> Tonsillitis
13. <input type="checkbox"/> Breathing Problems	30. <input type="checkbox"/> Emphysema	47. <input type="checkbox"/> Hemophilia	64. <input type="checkbox"/> Psychiatric Care	81. <input type="checkbox"/> Tuberculosis
14. <input type="checkbox"/> Bruise Easily	31. <input type="checkbox"/> Epilepsy or Seizures	48. <input type="checkbox"/> Hepatitis A	65. <input type="checkbox"/> Radiation Treatments	82. <input type="checkbox"/> Tumors or Growths
15. <input type="checkbox"/> Cancer	32. <input type="checkbox"/> Excessive Bleeding	49. <input type="checkbox"/> Hepatitis B or C	66. <input type="checkbox"/> Recent Weight Loss	83. <input type="checkbox"/> Ulcers
16. <input type="checkbox"/> Chemotherapy	33. <input type="checkbox"/> Excessive Thirst	50. <input type="checkbox"/> Herpes	67. <input type="checkbox"/> Renal Dialysis	84. <input type="checkbox"/> Venereal Disease
17. <input type="checkbox"/> Chest Pains	34. <input type="checkbox"/> Eye Disease	51. <input type="checkbox"/> High Blood Pressure	68. <input type="checkbox"/> Rheumatic Fever	85. <input type="checkbox"/> Yellow Jaundice

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 my dentist of any change in medical status.

Signature of Patient, Parent or Guardian

Date

Medical History Review

Doctors Signature

Date

DENTAL HISTORY

Date of last dental visit _____ Last dental cleaning _____ Last full mouth X-rays _____

What was done at your last dental visit? _____

Previous Dentist's name _____

Address _____

City _____ State _____ Zip _____

Telephone Number _____

How often do you have dental examinations done? _____ How often do you brush your teeth? _____

How often do you floss? What other dental needs do you use? tooth pick electric brush water pick other

Do you have any dental problems/concerns now? Yes No

If yes, describe _____

Are you sensitive to	Check one	Comment
Hot, cold or sweets?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Biting or Chewing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you noticed any mouth odors or bad taste?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you get cold sores, blisters or oral lesions?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do your gums bleed or hurt?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have your parents experienced gum disease or tooth loss?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you noticed any loose teeth or change in bite?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Does food tend to become caught in between your teeth? If yes, where?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Do you	Check one	Comment
Clench or grind your teeth while awake or asleep?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Bite your lips or cheeks regularly?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hold foreign objects with your teeth? (Pencils, pipe, pins, nails, fingernails, etc)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Mouth breathe while awake or asleep?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have tired jaws, especially in the morning?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Snore?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Stop breathing or gasp during sleep?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Have you ever had	Check one	Comment
Orthodontic treatment? (Braces)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Oral Surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Periodontal Treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
A bite plate or mouth guard?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Ground down teeth or bite adjustments	<input type="checkbox"/> Yes <input type="checkbox"/> No	
A serious injury to the mouth or head? If yes, please describe	<input type="checkbox"/> Yes <input type="checkbox"/> No	

DENTAL HISTORY continued

Have you experienced	Check one	Comment
Clicking or popping of the jaw?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Pain? (joint, ear, side of face)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Difficulty in opening/closing mouth?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Head, neck or shoulder aches?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Sore Muscles? (neck, shoulders)	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Are you satisfied with your teeth's appearance?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Would you like to keep all of your teeth for the rest of your life?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you feel nervous about having dental treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever had an upsetting dental experience? If yes, please describe	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is there anything else about having dental treatment that you would like us to know about?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

I certify that I have provided the above information to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my children or me during the period of such dental care to third party payers and/or health practitioners. I hereby authorize the dentist of Cheyenne Mountain Dental Center and the staff working under their supervision to perform whatever dental procedures are necessary to accomplish the agreed upon treatment. I certify that I am the patient or duly authorized general agent of the patient to furnish the information requested. I acknowledge that payment is due at the time of services unless other financial arrangements have been made. I understand that treatment will be billed to my dental insurance company (if applicable) as a courtesy and authorize all dental insurance payments to be paid to Cheyenne Mountain Dental Center. I agree that parents and guardians are responsible for all fees and services rendered for the treatment of a minor child and I am responsible for payment of services.

Signature of Patient, Parent or Guardian

Date

Dental History Review:

Doctors Signature

Date