bigheart
FAMILY DENTISTRY

1250 Burns Way, Suite #2
Kalispell, MT 59901
(406) 752-6776
frontdesk@bigheartfamilydentistry.com

Patient Information

Date _____ Email _____

Patient Name _____ Sex _____
First Middle Last

Address _____
Street City State Zip

Home Phone _____ Cell Phone _____ DOB _____

Occupation _____ SS# _____

Previous Dentist _____ Last Dental Visit _____

Spouse's Name _____ Cell Phone _____

If patient is a minor, name of parent/guardian _____

How did you hear about our office? _____

Responsible Party Information if other than patient or parent

Name _____ Relationship to Patient _____
First Last

Address _____
Street City State Zip

Home Phone _____ Cell Phone _____

Dental Insurance Information

Name of Policy Holder _____ SS# _____ DOB _____

Insurance Company _____ Group Number _____

Is the Patient covered by more than one Dental Insurance? Yes / No

Name of Policy Holder _____ SS# _____ DOB _____

Insurance Company _____ Group Number _____

_____ I understand that a copy of our clinic's Privacy Practices is available upon request.
Initial

_____ I grant Big Heart Family Dentistry permission to request and receive the dental records and radiographs from my previous dental clinics. I also grant Big Heart Family Dentistry permission to share my dental records and radiographs with other clinics for treatment and referral purposes.
Initial

_____ _____
Signature of Patient (or responsible party) Date

Patient Health History

1. Are you in good health? . . . . . **Yes / No**

2. My last physical examination by a medical doctor was on _____

3. Are you or have you ever been under the care of a physician, hospitalized, or had any serious operation or illness? . . . . . **Yes / No**
   - If so, for what medical condition(s)?

     _____

     _____

     _____

4. Name of Primary Care Physician and Clinic:

   _____

5. List all Allergies

   _____

   _____

   _____

6. Do you currently have or experienced any of the following conditions?

   - Congenital heart defect . . . . . **Yes / No**
   - Rheumatic fever/heart disease . . . **Yes / No**
   - Mitral valve prolapse . . . . . **Yes / No**
   - Heart attack . . . . . **Yes / No**
   - High blood pressure . . . . . **Yes / No**
   - Low blood pressure . . . . . **Yes / No**
   - Stroke . . . . . **Yes / No**
   - Diabetes . . . . . **Yes / No**
   - Reduced Kidney Function . . . . . **Yes / No**
   - Hepatitis (type:_____) **Yes / No**
   - Reduced Liver Function . . . . . **Yes / No**
   - HIV / AIDS . . . . . **Yes / No**
   - Blood or bleedings disorders . . . . **Yes / No**
   - Reduced Immune System . . . . . **Yes / No**
   - Seizures (type: _____) **Yes / No**
   - Asthma . . . . . **Yes / No**
     - *Do you carry an inhaler?* **Yes / No**

7. Have you ever experienced the following?

   - Chest pain upon exertion . . . . . **Yes / No**
   - Short of breath upon exertion . . **Yes / No**
   - Swollen ankles . . . . . **Yes / No**
   - Fainting or Dizziness . . . . . **Yes / No**
   - Urinate +6 times daily . . . . . **Yes / No**
   - Dry Mouth . . . . . **Yes / No**
   - Persistent cough . . . . . **Yes / No**
   - Abnormal bleeding . . . . . **Yes / No**

8. List all current medications and doses

   _____

   _____

   _____

   _____

   _____

   _____

9. Have you had any serious reaction to dental injections or treatment performed by a dentist? . . . . . **Yes / No**

   _____

   _____

   _____

10. Do you have a prosthetic joint? . . . . . **Yes / No**
    - If so, list part(s) of body and date of surgery:

      _____

      _____

      _____

11. Are you pregnant, could be pregnant or trying to become pregnant? . . . . . **Yes / No**

12. Do you use recreational drugs? . . . . . **Yes / No**

13. Do you use Tobacco/Nicotine products? . . . . . **Yes / No**
    - If so, how much, how often and in what form?

      _____

      _____

      _____

_____ _____

Signature Date