SALIDA
FAMILY DENTISTRY
Advanced Technology. Friendly Staff.

Brent Sites, DDS Keith Wilken, DMD Robert Provorse, DDS
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Patient Information

Date _____ Home Phone (_____)_____ Cell Phone (_____)_____

Name _____ Preferred Name _____
Last Name First Name Middle Initial

Address _____ Email _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Marital Status ☐ M ☐ S Birth Date _____ SS# _____

Other Family Members/Spouse that are current patients _____

Employer _____ Work Phone (_____)_____

Emergency Contact _____ Relationship _____ Phone (_____)_____

Best method to contact you? ☐ Home Phone ☐ Cell Phone ☐ Email How did you hear about us? _____

Insurance/Financial Policy

Subscriber (Name of Primary Person Insured) _____
Last Name First Name Middle Initial

Birth Date _____ Social Security Number (SS#) _____

Employer _____ Employer Phone (_____)_____

Insurance Company _____ Toll Free Phone (_____)_____

Insurance Mailing Address _____

Group# _____ Subscriber ID# _____ Payor ID# _____

Do you have any additional dental coverage (secondary dental insurance)? ☐ Yes ☐ No

I certify that I, and/or my dependent(s), have the above mentioned insurance and assign directly to Brent Sites, DDS; Keith Wilken, DMD and/or Robert Provorse, DDS of Salida Family Dentistry all insurance benefits, if any, otherwise payable to me for services rendered.

The above-named dentists may use my health care information and may disclose such information to the above-named Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or benefits payable for related services.

I understand that I am financially responsible for all charges whether or not paid by insurance.

I have reviewed and understand Salida Family Dentistry's Financial Policy. I agree to the terms of this Policy.

_____ _____ _____
Patient/Parent/Legal Guardian's Signature Print Name Date

HIPAA Privacy

I have reviewed Salida Family Dentistry's Privacy Policy. I agree to the terms of this Policy.

_____ _____ _____
Patient/Parent/Legal Guardian's Signature Print Name Date

Dental History

Why have you come to visit us today? _____

Previous Dentist _____ Date of Last Visit _____

Check if you experience any of the following:

☐ Bad Breath ☐ Bleeding Gums ☐ Grinding / Clenching Teeth ☐ Gums Tender / Swollen ☐ Pain in the Jaw

☐ Previous Periodontal/Gum Treatment:_____ ☐ Sensitivity to Hot / Cold / Sweets

How do you care for your teeth and gums? _____

Are you happy with your smile? ☐ Yes ☐ No I want my teeth straighter. ☐ Yes ☐ No I want my teeth whiter. ☐ Yes ☐ No

Medical History

Physician's Name _____ Office Location _____

Do you have any serious illnesses? ☐ Yes ☐ No Describe _____

Have you been hospitalized in the last 5 years? ☐ Yes ☐ No When/Why? _____

I usually take antibiotics prior to Dental Treatment? ☐ Yes ☐ No Name of Antibiotic? _____

Pharmacy Preference _____

Do you have or have you ever had any of the following? Circle Y for Yes or N for No:

Y	N	Artificial Heart Valves	Y	N	Headaches / TMJ	Y	N	Respiratory Disease
Y	N	Artificial Joints / Hip / Knee	Y	N	Heart Attack: Date_____	Y	N	Rheumatic Fever
Y	N	Asthma	Y	N	Hepatitis: Type _____	Y	N	Snoring / Sleep Apnea
Y	N	Bleeding Disorder	Y	N	High Blood Pressure	Y	N	Steroid Therapy
Y	N	Cancer	Y	N	HIV / AIDS	Y	N	Stroke: Date_____
Y	N	Chemotherapy	Y	N	Kidney Disease	Y	N	Thyroid Problems
Y	N	Diabetes	Y	N	Liver Disease	Y	N	Tobacco Use:_____
Y	N	Epilepsy	Y	N	Pacemaker	Y	N	Tuberculosis
Y	N	Fainting	Y	N	Radiation Treatment			

Allergies? ☐ Latex ☐ Penicillin ☐ Codeine ☐ Aspirin/Ibuprofen ☐ Sulfa Other: _____

Are you or have you taken Fosamax or bone density drugs? ☐ Yes ☐ No When? _____

Please list all medicine you are currently taking, and reason:

Medicine _____ Condition _____

Medicine _____ Condition _____

Medicine _____ Condition _____

Medicine _____ Condition _____

Doctor Notes: _____

_____

Consent for Treatment

I do hereby voluntarily consent to and/or authorize the performance of examinations, treatments, diagnostic procedures (including x-rays) which the doctor considers necessary and/or appropriate for myself, my child and/or dependent. This consent and agreement will remain in effect as long as patient remains in our practice.

_____ _____ _____

Patient/Parent/Legal Guardian's Signature Print Name Date