Erik Palmberg, DDS
(303) 741-4600

Patient Registration Information

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive, or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. *This office does not use this information to discriminate.*

ABOUT YOU

Today's Date:_____ Name: _____
Last First MI

Address:_____ City:_____ State:_____ Zip Code: _____

Home #: _____ Cell #: _____ Work #:_____ Daytime Call? _____

E-mail: _____ Birthdate: _____ Gender: ☐ Male ☐ Female

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Partnered Age: _____ Social Security #: _____

SPOUSE INFORMATION

Name: _____ Birthdate: _____ Social Security #: _____

Employer: _____ Cell #: _____ Work #: _____

PERSON RESPONSIBLE FOR THE ACCOUNT (Other than yourself)

Name: _____ Relation: _____ Social Security #: _____

Employer:_____ Occupation:_____ Cell #: _____ Home #:_____

Address:_____ City:_____ State:_____ Zip Code: _____

EMERGENCY CONTACT

Name: _____ Relation: _____ Cell #: _____

HOW DID YOU HEAR ABOUT US?

Who may we thank for referring you?_____ Comments: _____

PRIMARY INSURANCE

Subscriber Name:_____

Subscriber ID: _____

Date of Birth: _____

Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Employer Name: _____

Employer Phone: _____

Insurance Company:_____

Insurance Group: _____

Insurance Phone: _____

Insurance Address:_____

_____

SECONDARY INSURANCE

Subscriber Name:_____

Subscriber ID: _____

Date of Birth: _____

Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Employer Name: _____

Employer Phone: _____

Insurance Company:_____

Insurance Group: _____

Insurance Phone: _____

Insurance Address:_____

_____

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HEALTH HISTORY

Reason for today's visit? _____ Date of last dental visit? _____

Former dentist? _____ Date of last dental x-rays? _____

DENTAL

Bad breath ☐ Y ☐ N
Blisters on lips or mouth ☐ Y ☐ N
Burning sensation on tongue ☐ Y ☐ N
Chew on one side of mouth ☐ Y ☐ N
Cigarette, pipe, or cigar smoking ☐ Y ☐ N
Smokeless tobacco ☐ Y ☐ N
Dry mouth ☐ Y ☐ N
Food collection between teeth ☐ Y ☐ N
Clench or grind teeth ☐ Y ☐ N
Growth or sore spots in mouth ☐ Y ☐ N

Gums, swollen, tender or bleeding ☐ Y ☐ N
Head, neck, jaw pain, or aches ☐ Y ☐ N
Lip or cheek biting ☐ Y ☐ N
Loose teeth or broken fillings ☐ Y ☐ N
Mouth breathing ☐ Y ☐ N
Orthodontic treatment ☐ Y ☐ N
Nitrous Oxide ☐ Y ☐ N
Periodontal treatment ☐ Y ☐ N
Sensitivity to pressure or irritants ☐ Y ☐ N
(Cold, Heat, Sweets)

Have you ever had an allergic reaction to anesthetics? ☐ Y ☐ N
If Yes, please explain: _____
Have you ever had trouble from previous dental care? ☐ Y ☐ N
If Yes, please explain: _____
_____
How often do you floss? _____
How often do you brush? _____
Are you interested in teeth whitening? ☐ Y ☐ N
Do you have questions about any of the following? (circle)
…. Fluoride …. Crowns …. Periodontal Disease …. Veneers ….
… TMJ …. Implants …. Dentures …. Teeth Whitening …. Other

MEDICAL

Physician name? _____ Date of last visit? _____ Blood pressure: _____

Have you had any serious illnesses or operations? .. ☐ Yes ☐ No If yes, please describe: _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, approximate dates? _____

(Women) Are you pregnant? ☐ Yes ☐ No Due date? _____ Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Allergies, hay fever, sinusitis ☐ Y ☐ N
Anemia ☐ Y ☐ N
Arthritis, Rheumatism ☐ Y ☐ N
Artificial heart valves ☐ Y ☐ N
Artificial joints ☐ Y ☐ N
Asthma ☐ Y ☐ N
Have you used steroids? ☐ Y ☐ N
Bleeding abnormally w/ surgery ☐ Y ☐ N
Blood disease – clotting disorders ☐ Y ☐ N
Cancer ☐ Y ☐ N
Chemical dependency ☐ Y ☐ N
Chemotherapy ☐ Y ☐ N
Circulatory problems ☐ Y ☐ N
Cortisone treatments ☐ Y ☐ N
Cough, persistent or bloody ☐ Y ☐ N
Diabetes ☐ Y ☐ N
Emphysema ☐ Y ☐ N
Epilepsy ☐ Y ☐ N

Fainting ☐ Y ☐ N
Heart murmur ☐ Y ☐ N
Heart problems ☐ Y ☐ N
Hepatitis type _____
Herpes ☐ Y ☐ N
High / low blood pressure ☐ Y ☐ N
Any immune deficiency ☐ Y ☐ N
Jaundice ☐ Y ☐ N
Kidney disease ☐ Y ☐ N
Osteoporosis ☐ Y ☐ N
Pacemaker ☐ Y ☐ N
Radiation treatments ☐ Y ☐ N
Respiratory disease ☐ Y ☐ N
Rheumatic fever ☐ Y ☐ N
Scarlet fever ☐ Y ☐ N
Sinus trouble ☐ Y ☐ N
Sickle cell anemia ☐ Y ☐ N
Skin rash ☐ Y ☐ N

Slow healing wounds? ☐ Y ☐ N
Stroke? ☐ Y ☐ N
Swelling of feet or ankles? ☐ Y ☐ N
Thyroid problems? ☐ Y ☐ N
Tonsillitis? ☐ Y ☐ N
Tuberculosis? ☐ Y ☐ N
Tumor or growth on head/neck? ☐ Y ☐ N
Ulcer? ☐ Y ☐ N
Venereal disease? ☐ Y ☐ N
Weight loss, unexplained? ☐ Y ☐ N
Are you allergic/sensitive to Latex? ☐ Y ☐ N
Allergic to Penicillin, Aspirin, or other drugs? ☐ Y ☐ N
If Yes, please explain: _____
_____
List any medications that you are are taking:
_____
_____
_____

AUTHORIZATION

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. 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 me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all service rendered on my behalf or my dependents.

Signature: _____ Date: _____

(Guardian must sign if Patient is under 18 years of age)

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Interview

I Like My Teeth (1-10) 1 2 3 4 5 6 7 8 9 10

If I could, I would like to change _____

I have had …. Braces …. Fillings …. Crowns …. Root Canals …. Implants …. Extractions … Veneers …. Bleaching …. Dentures …..

_____

_____

Goals

I would like to keep my natural teeth…	Until it costs too much	Until they hurt	Until something better comes along		For the rest of my life
How Important is keeping your teeth?	Not at all	Somewhat	Moderately	Very	Tooth loss is not an option
If I lost a tooth tomorrow I would…	_____		_____		
What is your desired level of care?	Minimal	Reactive (when it hurts)	Proactive	Ideal	Other (Cosmetic, Reconstructive, etc)
I see the dentist for…	Just cleanings	Basic dental care	Premier dental care		Wellness dental care
I am concerned about dental esthetics…	Not at all	Somewhat	Moderately	Very	I have concerns now
I am concerned about dental pain…	Not at all	Somewhat	Moderately	Very	I have pain now
I am concerned about dental function…	Not at all	Somewhat	Moderately	Very	I have functional issues now
I am concerned about my gum health…	Not at all	Somewhat	Moderately	Very	I have gum issues now
My current state of dental health is…	Poor	Fair	Moderate	Good	Excellent

History Detail

My most Recent Dental Exam	n/a	<6mo	6-12mo	12-18mo	18-36mo	3-5yr	>5yr
My most recent dental cleaning	n/a	<6mo	6-12mo	12-18mo	18-36mo	3-5yr	>5yr
My most recent filling	n/a	<6mo	6-12mo	12-18mo	18-36mo	3-5yr	>5yr
My most recent crown	n/a	<6mo	6-12mo	12-18mo	18-36mo	3-5yr	>5yr
My most recent root canal	n/a	<6mo	6-12mo	12-18mo	18-36mo	3-5yr	>5yr
My most recent extraction	n/a	<6mo	6-12mo	12-18mo	18-36mo	3-5yr	>5yr
My most recent dental pain	n/a	<6mo	6-12mo	12-18mo	18-36mo	3-5yr	>5yr

What is something you would like the Dental team to know about you? _____ _____

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Doctor's Notes