Scott W. Martinsen, DDS *Valerie R. Martinsen, DDS*

MEDICAL and DENTAL HISTORY

Patient Name: ______________________________

Are you under a physician's care now? O Yes O No ____________
Have you ever been hospitalized or had a major operation? O Yes O No ____________
Have you ever had a serious head or neck injury? O Yes O No ____________
Have you ever taken Phen-Phen or a bisphosphonate medication? O Yes O No ____________
Are you taking any medication, pills, or drugs? O Yes O No please list: ____________
Do you use cigarettes or smokeless tobacco? O Yes O No # packs/day: ____________
Do you or have you ever abused controlled substances? O Yes O No ____________
Women: Are you O pregnant/trying to get pregnant? O nursing? O taking oral contraceptives?

Are you allergic to any of the following: O Latex O Aspirin O Penicillin O Codeine O Acrylic O Local Anesthetics O Other

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

O AIDS/HIV Positive
O Alzheimer's Disease
O Anaphylaxis
O Angina
O Artificial Heart Valve*
O Artificial Joint*
O Asthma
O Autoimmune Disease
O Blood Disease/Disorder
O Breathing Problem
O Cancer or Tumor
O Chemotherapy
O Cold Sores/Fever Blisters
O Congenital Heart Disorder*
O Cortisone Medicine
O Convulsions
O Depression
O Diabetes
O Emphysema
O Epilepsy or Seizures
O Excessive Bleeding
O Fainting/Dizzy Spells
O Frequent Headaches
O Glaucoma
O Heart Attack/Failure
O Heart Murmur*
O Heart Pace Maker
O Heart Disease
O Hemophilia
O Hepatitis A, B, or C
O Herpes
O High Blood Pressure
O Hives or Rash
O Hypoglycemia
O Leukemia
O Liver Disease
O Low Blood Pressure
O Lung Disease
O Mitral Valve Prolapse
O Neurological Disorder
O Pain in Jaw Joints (TMJ)
O Psychiatric Care
O Radiation Therapy
O Recent Weight Loss
O Renal Dialysis
O Rheumatic Fever*
O Sickle Cell Disease
O Sinus Trouble
O Stroke
O Thyroid Disease
O Tuberculosis
O Ulcers

* may require premedication

Please state the reason for your visit. ______________________________

When was your last dental visit? ______________________________
Were X-rays taken at that time? O Yes O No
Are you in pain or discomfort now? O Yes O No
Do you gums bleed or feel tender? O Yes O No
Are your teeth sensitive to hot, cold, or sweets? O Yes O No
Are your teeth loose? O Yes O No
Do you grind, clench, or grit your teeth? O Yes O No
Does your jaw ever click or cause pain on opening or closing? O Yes O No
Do or did you wear braces? O Yes O No
Do you wear dentures and/or partial dentures? O Yes O No
If yes, are you satisfied with your present dentures? O Yes O No
Have you ever experienced any growths or sore spots in your mouth? O Yes O No

Have you ever had a serious illness not listed above? O Yes O No ____________

To the best of my knowledge, all of the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in health or medication.

______________________________ ____________

Signature of Patient or Legal Guardian Date

In order to help us render the proper dental services to you, would you please be kind enough to answer the following questions.
Thank you for your cooperation.

PATIENT INFORMATION

DATE:______________________ SOCIAL SECURITY #:________________________ AGE:__________ BIRTHDATE:________________

PATIENT'S NAME:____

IF MINOR, GUARDIAN'S NAME:____

PATIENT'S ADDRESS:____

PHONE #:____

RESPONSIBLE PARTY INFORMATION

RESPONSIBLE PARTY'S NAME:____

RESPONSIBLE PARTY'S ADDRESS:____

RESPONSIBLE PARTY'S SS#:____

RESPONSIBLE PARTY'S EMPLOYER:____

OCCUPATION:______________________ WORK PHONE #:______________________ EXT:______________

ADDRESS:____

SPOUSE'S NAME:____

SPOUSE'S ADDRESS:____

SPOUSE'S PHONE #:____

SPOUSE'S EMPLOYER:__________________ WORK PHONE #:______________________ EXT:______________

IN CASE OF EMERGENCY, CONTACT (SOMEONE NOT LIVING WITH YOU):______________________________

COMPLETE ADDRESS:____ PHONE:__________________

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?:______________________________

DENTAL INSURANCE			SECONDARY DENTAL INSURANCE		
INSURED'S NAME:			INSURED'S NAME:		
INSURANCE COMPANY:			INSURANCE COMPANY:		
ADDRESS:			ADDRESS:		
CITY:	STATE:	ZIP:	CITY:	STATE:	ZIP:
INSURED'S EMPLOYER:			INSURED'S EMPLOYER:		
INSURED'S SSN:			INSURED'S SSN:		
GROUP #:	DATE OF BIRTH:		GROUP #:	DATE OF BIRTH:	

IF YOU HAVE DENTAL INSURANCE, WE WILL BE HAPPY TO ASSIST YOU IN PROCESSING YOUR CLAIM. YOU MUST REALIZE THAT YOUR INSURANCE COMPANY HAS AN OBLIGATION TO YOU AND NOT TO THE DENTIST.

AGREEMENT FOR PAYMENT: I AGREE TO PAY FOR ALL SERVICES RENDERED ON THE DAY OF TREATMENT OR WITHIN THIRTY DAYS OF RECEIPT OF STATEMENT, OR IN ACCORDANCE WITH A PRE-ESTABLISHED PLAN. DELINQUENT ACCOUNTS WILL BE SUBJECT TO LEGAL PROCEEDINGS.

ASSIGNMENT & RELEASE: I, THE UNDERSIGNED CERTIFY THAT I (OR MY DEPENDENT) HAVE INSURANCE COVERAGE AND ASSIGN DIRECTLY TO DR. SCOTT W. MARTINSEN, DDS OR DR. VALERIE R. MARTINSEN, DDS ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

______________________________ ______________________________
PATIENT OR GUARDIAN SIGNATURE SIGNATURE OF RESPONSIBLE PARTY