Stephen G. Blank, DDS

PATIENT

Last Name _____ First _____ Middle _____ Sex M F

Address _____ City _____ State _____ Zip _____

Home Phone _____ Soc. Sec. # _____ Date of Birth _____ Spouse _____

Work Phone _____ Marital Status _____ E-Mail _____

Cell Phone _____ Responsible Party _____ Relationship _____

In Case of Emergency Call _____ Relationship _____ Phone _____

Whom may we thank for referring you to this office? _____

Place of Employment _____ May we call you at work? YES NO

Physician Name _____ Phone _____ Date of Last Visit _____

Surgical Procedures Last 12 months _____

_____

Current Medical Treatment _____

_____

Current Medications (Rx, Vitamins, Supplements) _____

Pre Medicate YES NO (for: Heart Valve, Joints, implants) _____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING ?

YES	NO	HEART ATTACK, CHEST PAIN, ANGINA - NITRO TABS	YES	NO	DIABETES , DIET CONTROLLED, INSULIN
YES	NO	HEART MURMUR, MITRAL VALVE PROLAPSE (MVP)	YES	NO	CANCER: Type _____ Date _____
YES	NO	RHEUMATIC HEART FEVER, ARTIFICIAL HEART VALVES	YES	NO	ARTHRITIS
YES	NO	HIGH or LOW BLOOD PRESSURE	YES	NO	KIDNEY DISEASE
YES	NO	BYPASS OR ANGIOPLASTY	YES	NO	SMOKER, EMPHYSEMA, C.O.P.D, ASTHMA
YES	NO	PACEMAKER	YES	NO	ULCERS, COLITIS, INTESTINAL DISORDERS
YES	NO	STROKE	YES	NO	HERPES or COLD SORES, CANKER SORES
YES	NO	ALLERGIES: PENICILLIN ERYTHROMYCIN LATEX	YES	NO	HIV OR AIDS
YES	NO	Other Allergies _____	YES	NO	LIVER DISEASE, HEPATITIS A OR B OR C
YES	NO	ARTIFICIAL JOINTS: HIP KNEE OTHER	YES	NO	EPILEPSY OR SEIZURES
YES	NO	CURRENTLY PREGNANT, NURSING, BIRTH CONTROL	YES	NO	BLOOD TRANSFUSIONS, Hospitalized last 2 years
YES	NO	OSTEOPOROSIS, Bisphosphonate medication	YES	NO	APNEA SNORING Do you have a CPAP Machine?

Do you feel well ? YES NO Do you have any other disease, infection or medical condition that we should be aware of ? _____

_____

_____

Patient Signature or Guardian **Date**

MEDICAL HISTORY

Stephen G. Blank, DDS

Questionnaire

Name _____ Date _____

These are things that are important to me about my dental health: (Please check one)

1. ❑ My mouth is very comfortable.
   ❑ My mouth is moderately comfortable.
   ❑ My mouth is uncomfortable.

2. ❑ I feel that the appearance of my mouth is very good.
   ❑ I am satisfied with the appearance of my mouth.
   ❑ I am dissatisfied with the appearance of my mouth.

3. ❑ I will do anything to keep my natural teeth.
   ❑ I want to keep my natural teeth, but have certain budgets of time and money I am willing to spend on them.
   ❑ I don't care whether I keep my teeth or not.

4. ❑ I have set goals for my oral health with a previous dentist.
   ❑ I want to set goals concerning my dental health.
   ❑ I am not interested in thinking about the future of my teeth at this time.

5. ❑ I have always completed the care that was recommended for my dental health.
   ❑ I have not done what dentists have recommended for my mouth.
   ❑ I rarely go to the dentist and only do what is necessary to be free of pain and cosmetic embarrassment.

6. ❑ I have put dentistry for myself and my family high on my priority list.
   ❑ I have put dentistry for myself and my family low on my priority list.
   ❑ I have put dentistry for myself and my family on my list but it is hard to find.

7. I think my present state of dental health is:
   ❑ Excellent.
   ❑ Average.
   ❑ Don't have a clue.

8. Should I require some form of treatment, the following best describes my feelings about the types of dental restorations that I would like in my mouth:
   ❑ I want the best restoration possible that will be the most conservative and give the longest life.
   ❑ I want all of the above and I want only tooth colored restorations, even though they may not be as durable and require more care and a greater investment.
   ❑ I want the least expensive restoration that will get me by for now.

9. Please select the single factor that best describes your reason for getting dental care. (Check only one.)
   ❑ Desire to avoid pain.
   ❑ Desire to look my best.
   ❑ Desire to intercept problems early and to avoid preventable expenses in the future.
   ❑ Desire to avoid dentures.
   ❑ Other _____

10. Please describe in the order of importance your concerns about your mouth now, as well as any questions that you have always wanted answered about your mouth:

QUESTIONNAIRE

CONSENT FOR RELEASE OF MEDICAL RECORDS AND INFORMATION

By signing this form you are granting consent to Dr. Stephen Blank and Staff to use and disclose your protected health information for the purpose of treatment, payment, referral, insurance and healthcare operations. Our Notice of Privacy Practice (NOPP) provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our NOPP before you sign this consent and we encourage you to read it in full.

I authorize Dr. Blank and his practice to send un-encrypted e-mail regarding my dental health, medical conditions, and radiographs (x-rays) to other healthcare practitioners or insurance companies as needed for referrals and for transfer of my records to myself (patient) or anyone the patient directs.

I authorize Dr. Blank and/or Staff to call, text or email appointment reminders and other care related messages to my:

☐ home phone ☐ cell ☐ work ☐ email

I understand I can withdraw my consent at any time.

Text Cell # _____ *Email Address:* _____

I authorize the Dr. Blank and/or his Staff to allow into the treatment room and discuss my care in office or on the phone with, and release information to the following listed individuals:

_____

Name Relationship Phone

_____

Name Relationship Phone

By Patient:_____

(Printed name above)

_____

(Signature above) Date:

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