Date______________ Patient Name______________________________________ Name you wish to be called______________

Physical Address____ Home Phone______________________

City_________________________________ State________ Zip Code______________ Work Phone______________________

Mailing Address____ Cell Phone______________________

City____ State__________ Zip Code______________

Best Time and Place to Reach You ____

Sex: ☐M ☐F Age______ Birthdate_____________ ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Patient SS#___________________________ Occupation___________________________ Employer______________________

Spouse Name____Birthdate____________ SS#________________________________

Spouse's Employer____ Spouse's Work Phone________________

Who is responsible for this account?______________________________ Relationship to patient_________________________

IN CASE OF EMERGENCY PLEASE CONTACT (someone not living with you)

Name____ Relationship to you________________________

Address and Phone Number of Emergency Contact Person____

Whom may we thank for referring you?____

Insurance Company____Group#____________

Is patient covered by additional insurance ☐yes ☐no Subcriber's name____

Subscriber's Birthday_____________ Subscriber's SS#__________________ Relationship to Patient_______________________

Insurance Company____Group#____________

ASSIGNMENT AND RELEASE

I, undersigned, certify that I (or my dependent) have insurance coverage with
and assign directly to doctor otherwise payable to me for services rendered. I understand that I am financially responsible for 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. To the extent permitted by law, I consent to your use and disclosure of my PHI (protected health information) to carry out payment activities in connection with my claims. I have received a copy of Dr. Blehm's privacy practices.

Responsible Party Signature___________________________________ Relationship_______________________ Date____________

DENTAL HISTORY

Reason for today's visit____

Former Dentist____

Date of last visit___________________________________ Date of last dental X-rays____________________________________

Please initial Yes or No to indicate if you have had any of the following:

Bad Breath ____ Yes ____ No
Bleeding gums ____ Yes ____ No
Blisters on lips or mouth ____ Yes ____ No
Burning sensation on tongue ____ Yes ____ No
Broken Fillings ____ Yes ____ No
Cigarette, pipe or cigar smoking ____ Yes ____ No
Chewing tobacco ____ Yes ____ No
Chew on one side of mouth ____ Yes ____ No
Clicking or Popping Jaw ____ Yes ____ No
Dry Mouth ____ Yes ____ No

Do you or have you ever experienced pain/discomfort in your jaw joint ____ Yes ____ No
Fingernail biting ____ Yes ____ No
Food collection between teeth ____ Yes ____ No
Grinding Teeth ____ Yes ____ No
Gums swollen ____ Yes ____ No
Jaw pain or tiredness ____ Yes ____ No
Lip or cheek biting ____ Yes ____ No
Loose Teeth ____ Yes ____ No
Mouth breathing ____ Yes ____ No
Orthodontic treatment ____ Yes ____ No
Pain around ear ____ Yes ____ No

Periodontal Disease ____ Yes ____ No
Sensitivity to cold ____ Yes ____ No
Sensitivity to heat ____ Yes ____ No
Sensitivity to sweets ____ Yes ____ No
Sensitivity when biting ____ Yes ____ No
Sores or growths in your mouth ____ Yes ____ No
Have you ever had a serious or difficult problem associated with previous dental work ____ Yes ____ No
Do you like your smile? ____ Yes ____ No
How often do you brush?______________
Type of bristles? ______________
How often do you floss?______________

Medical History

Physician's Name & Number ______________________ Date of last visit______________

Please initial yes or no to indicate if you have had any of the following:

Condition	Yes	No
AIDS	____ Yes	____ No
Anemia	____ Yes	____ No
Arthritis, Rheumatism	____ Yes	____ No
Artificial Heart Valves	____ Yes	____ No
Artificial Joints	____ Yes	____ No
Asthma	____ Yes	____ No
Back problems	____ Yes	____ No
Bleeding abnormally (with extraction or surgery)	____ Yes	____ No
Blood Disease	____ Yes	____ No
Cancer	____ Yes	____ No
Chemical dependency	____ Yes	____ No
Chemotherapy	____ Yes	____ No
Circulatory problems	____ Yes	____ No
Congenital Heart Lesions	____ Yes	____ No
Cortisone treatments	____ Yes	____ No
Cough, Persistent or bloody	____ Yes	____ No
Diabetes	____ Yes	____ No
Do you wear Contact Lenses	____ Yes	____ No
Epilepsy	____ Yes	____ No
Fainting or dizziness	____ Yes	____ No
Glaucoma	____ Yes	____ No
Headaches	____ Yes	____ No
Heart Murmur	____ Yes	____ No
Heart Problems	____ Yes	____ No
Hepatitis	____ Yes	____ No
Type________		
Herpes	____ Yes	____ No
High Blood Pressure	____ Yes	____ No
Meds:_____		
HIV Positive	____ Yes	____ No
Jaundice	____ Yes	____ No
Kidney Disease	____ Yes	____ No
Liver Disease	____ Yes	____ No
Low Blood Pressure	____ Yes	____ No
Mitral Valve Prolapse	____ Yes	____ No
Nervous Problems	____ Yes	____ No
Women:		
Are you pregnant?	____ Yes	____ No
Due date____		
Are you nursing?	____ Yes	____ No
Are you taking birth control pills?	____ Yes	____ No
Psychiatric Care	____ Yes	____ No
Radiation Treatment	____ Yes	____ No
Respiratory Disease	____ Yes	____ No
Rheumatic Fever	____ Yes	____ No
Scarlet Fever	____ Yes	____ No
shortness of Breath	____ Yes	____ No
Sinus Trouble	____ Yes	____ No
Skin Rash	____ Yes	____ No
Special Diet	____ Yes	____ No
Stroke	____ Yes	____ No
Swelling or Feet or ankles	____ Yes	____ No
Swollen Neck Glands	____ Yes	____ No
Thyroid Problems	____ Yes	____ No
Tonsillitis	____ Yes	____ No
Tuberculosis	____ Yes	____ No
Tumor or growth on Head or Neck	____ Yes	____ No
Ulcer	____ Yes	____ No
Venereal Disease	____ Yes	____ No
Weight Loss, Unexplained	____ Yes	____ No
Any hospital stays	____ Yes	____ No

Explain______________________________

____

____

MEDICATIONS

Please list medications you are currently taking:

____

____

____

Pharmacy Name ______________________

Phone______________________

ALLERGIES (please initial)

____ Aspirin
____ Barbiturates (sleeping pills)
____ Codeine
____ Iodine
____ Latex
____ Local Anesthetic
____ Penicillin
____ Sulfa
____ Other______________

____

I understand I am responsible for my account regardless of my insurance. I also understand that my insurance is an agreement between me and my insurance company.

I understand that I may be charged a $2.00 per month if my balance goes beyond 30 days

I agree to pay collection fees including court cost and attorney fees in case of default on payment due.

I give permission for my dentist and clinical team to take any necessary radiographs,study models, and photographs to make a complete diagnosis of my dental needs. I also give permission to use this information for educational purposes in-office.

______________________________ ______________________

Patient's Signature Date

______________________________ ______________________

Doctor's Signature Date

(I have read, agree to, and understand the statements listed above)

GENERAL CONSENT

Thank you for choosing our office for your dental care. We will work with you to help you achieve excellent oral health. While recognizing the benefits of a pleasing smile and teeth that function well, you should be aware that dental treatment, like treatment of any other part of the body, has some inherent risks. These are seldom great enough to offset the benefits of treatment, but should be considered when making treatment decisions.

Benefits of dental treatment can include: relief of pain, the ability to chew properly, and the confidence and social interaction that a pleasing smile can bring. Nonetheless, there are some common risks associated with virtually any dental procedure, including:

1. **Drug or chemical reaction.** Dental materials and medications may trigger allergic or sensitivity reactions.
2. **Long-term numbness (paresthesia).** Local anesthetic, or its administration, while almost always adequate to allow comfortable care, can result in transient, or in rare instances, permanent numbness.
3. **Muscle or joint tenderness.** Holding one's mouth open can result in muscle or jaw joint tenderness, or in a predisposed patient, precipitate a TMJ disorder.
4. **Sensitivity in teeth or gums, infection, or bleeding.**
5. **Swallowing or inhaling small objects.**

While we follow procedural guidelines which most often lead to a clinical success, just like in any other pursuit in health care, not everything turns out the way it is planned. We will do our best to assure that it does. Please feel free to ask questions in regard to all dental procedures that are recommended to you.

I have read and understand the statement on this page:

____________________________ ____________

Patient's signature Date

____________________________ ____________

Parent's signature (if minor patient) Date