We know paperwork is long and difficult, it is important for us to deliver proper care and stay in compliance with all the laws surrounding the healthcare profession. Bear with us, we really do stick to the basics.

____ Mr ____ Mrs ____ Ms ____ Miss

Full Name: *First* *Middle* *Last* *Suffix?* *Sr. Jr. III*

Phone: *Home* *Cell* *Work* *Date of Birth:*

Address: *Street* *Apt. #* *City* *State* *Zip*

Email: Gender M F ___ Married ___ Widowed ___ Other

How did you hear about us? Dr. _____ Friend Family Website Hospital Newspaper Other

Did you ever serve in any branch of the military? Yes No Which?

IDA is proud to give the retired military a discount on new dentures in honor of your service. Thank-you

What is your reason for coming in today?

When was your last dental visit? Previous Dentist:

Dental Pain	Yes No	Do you grind your teeth?	Yes No	Walker	Yes No
Sensitive teeth	Yes No	Do you bite your lips or cheek?	Yes No	Wheelchair	Yes No
Sores on gums	Yes No	Did you ever have braces?	Yes No	Cane	Yes No
Sores under denture	Yes No	Do you get frequent headaches?	Yes No	Glasses	Yes No
Cavities/Broken teet	Yes No	Do you have jaw pain?	Yes No	Hearing aids	Yes No
Infected Teeth	Yes No	Does your jaw click or pop?	Yes No	Care Manager:	
Extractions Needed?	Yes No	Have you broken your jaw?	Yes No		Yes No
Mouth Cancer	Yes No	Can you eat most foods you wan	Yes No	Name:	
Implants present	Yes No	Are you eating a healthy diet?	Yes No		

Are you wearing dentures now? Yes No How old are they? _____ What age did you first get a denture? _____

Please check all of the following are you hoping we will do:

Make new denture	Start first denture	Make a partial	
Re-fit old denture	Add teeth to partial	Replace missing tooth	
Repair my denture	I'm not certain	Perform a miracle	

Guide me through the process of having my natural teeth out and getting dentures for the first time.

OTHER:

Insurance Only

Phone: Group # ID#

Your Social Security # Employer:

If this insurance is through somebody other than you, we need the following in order to help utilize it for your care.

Their Employer: _____ Their Date of Birth: _____ Their Social Security# _____

Insurance is a contract between you and the insurance company, no dental office is responsible for the amount insurance pays for care.

We will do our best to help with insurance claims, however, we cannot guarentee payment. If you have questions, please ask!

I authorize payment directly to Inverness Dental Arts, LD for my dental benefits.

Signature needed or we cannot bill your insurance for you.

Your treatment plan is designed to take many factors into consideration and the most important is your health.
If there is something we didn't ask about or something that is best talked about, please bring it up.

Do you see a primary care physician on a regular basis? Yes No Who: _____

Allergies -

___ LATEX ___ ASPIRIN ___ SILICONE ___ ACRYLIC ___ METALS ___ Medication: _____ Other: _____

Cardiovascular				**Respiratory**				**General Health**			
Heart Attack/Failure	Yes	No		COPD	Yes	No		Frequent Steroid Medicine	Yes	No	
Heart Surgery	Yes	No		Asthma	Yes	No		Pregnant	Yes	No	Months ___
Stent/Shunt	Yes	No		Inhailers	Yes	No		Hepatitis/Liver disorder	Yes	No	
Angina/Chest Pain	Yes	No		C-PAP Machine	Yes	No		Kidney disorder/Dialysis	Yes	No	
Blood Presssure OK	High	Low		Oxygen Use	Yes	No		Shingles	Yes	No	
Heart Murmur	Yes	No		Lung Surgery	Yes	No		Sinus Trouble	Yes	No	
Heart Defect	Yes	No		Emphysema	Yes	No		Chronic Facial Pain	Yes	No	
Valve Replacement	Yes	No		Tuberculosis	Yes	No		Headaches/Migraine	Yes	No	
Abnormal Rhythm	Yes	No		Easily Winded	Yes	No		Arthritis	Yes	No	
Blood Thinner	Yes	No		Smoker (Past)	Yes	No		Alzheimer/Dimentia	Yes	No	
Last INR Blood Work	/ /			Smoker (Now)	Yes	No		Aids/HIV	Yes	No	
Pace Maker	Yes	No		Chew Tobacco (Past)	Yes	No		Eilepsy or Seisures	Yes	No	
Stroke	Yes	No		Chew Tobacco (Now)	Yes	No		Fainting/Dizzy spells	Yes	No	
Excessive Bleeding	Yes	No		OTH: Breathing issue	Yes	No		Cold Sore/Fever Blisters	Yes	No	
High Cholesterol	Yes	No		Explain:				Thyroid Disease	Yes	No	
Valve Prolapse	Yes	No						Psychiatric Care	Yes	No	
OTHER Heart Problem	Yes	No		**Digestive Health**				Addiction (Past)	Yes	No	
Explain:				Diabetic	Yes	No		Addiction (Now)	Yes	No	
Nitroglycerin Tablets	Yes	No		Diet Medication Insulin				**Cancer/Tumor History**			
Where are they:				Hypoglycemia	Yes	No		Cancer (Past)	Yes	No	
Bones & Joints				Ulcers	Yes	No		Cancer (Now)	Yes	No	
Osteoporosis	Yes	No		Gastric Reflux	Yes	No		Location:			
Bisphosphonates	Yes	No		Chrones/Colitis/IBS	Yes	No					
Fosamax, Boniva etc:	Yes	No		Special Diet	Yes	No		Radiation	Yes	No	
Artificial Joint	Yes	No		Digestion Problems	Yes	No		Last Treatement Date:			
Where: _____				Inability gain weight	Yes	No		ChemoTherapy	Yes	No	
Pins/Metal Repair	Yes	No		Inability loose weight	Yes	No		Last Treatment Date:			

Medications: Please list or we are happy to scan your list, they are important to your care.

Other health concern not listed above:

We will respect your privacy and offer you a copy of the HIPAA Health Information Portability Accountability Act,
In the event of an emergency which requires an ambulance, we will need to share your health information with the

Do you want a full copy of the HIPPA document to take home with you? Yes No
Do we have permission to provide information to ambulance personel in an emergency? Yes No

Who do we contact in an emergency? Name: _____ Phone: _____

SIGNATURE DATE

We need your signature above, so please remember to sign it!