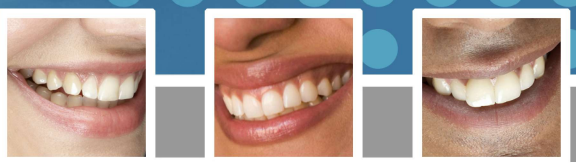
Summit Family Dental Care
906 Royal Court
Medford, OR 97504

(541)779-2634
offce@summitdmd.com



Patient Information

Chart #. _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ SS #. _____ Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) _____ (Fax) _____ (Other)

Address: _____
_____ (City) _____ (State) _____ (Zip Code)

If the patient is a minor, who is the patient's parent or legal guardian?

Emergency contact name and phone number

Whom may we thank for referring you?

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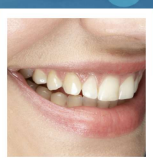
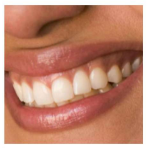
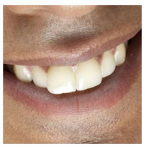

Dental Insurance

Name of Insured: _____ (Last) _____ (First) ____ (MI)

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____ _____

_____ (City) ____ (State) _____ (Zip Code)

Insured's Employer Name: _____

Employer Address: _____ _____

_____ (City) ____ (State) _____ (Zip Code)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____

_____ (City) ____ (State) _____ (Zip Code)

Insurance Authorization

☐ By checking this box,
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all changes whether or not paid by insurance.

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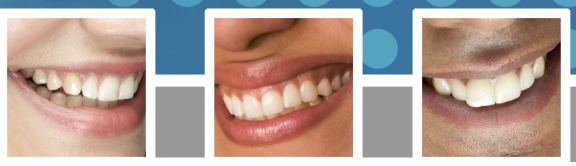

Secondary Dental Insurance

Name of Insured: _____ (Last) _____ (First) _____ (MI)

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Insured's Employer Name: _____

Employer Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

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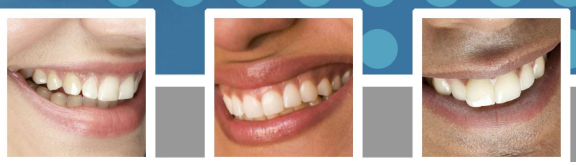

Dental History

Reason for today's visit

Former Dentist and City, State

Date of last dental visit

Date of last X-rays

Are you happy with your smile, if not what are your concerns?

On a scale from 1-10, 10 being extreme, where do you rank your dental anxiety?

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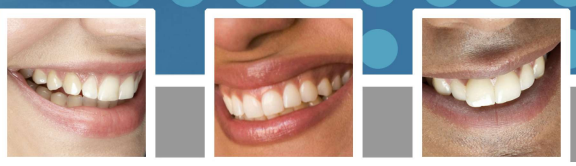

Dental History (Cont.)

Please check the appropriate box if you have had any of the following:

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Blisters on Mouth
- ☐ Broken Teeth/ Fillings
- ☐ Burning Mouth
- ☐ Dry Mouth
- ☐ Fingernail Biting
- ☐ Food Collection Between Teeth
- ☐ Grinding/ Clenching Teeth
- ☐ Gum Pain/ Swelling
- ☐ Jaw Pain
- ☐ Jaw Clicking/ Popping
- ☐ Lip/ Cheek Biting
- ☐ Loose Teeth
- ☐ Missing Teeth
- ☐ Orthodontic Treatment
- ☐ Periodontal Treatment
- ☐ Sensitivity to Hot or Cold
- ☐ Sensitivity to Biting
- ☐ Sensitivity to Sweets
- ☐ Tobacco Use
- ☐ Tooth Pain

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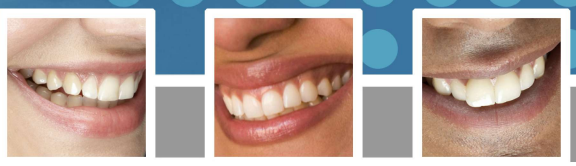

Medical History

Please check all that apply:

- [ ] Abnormal Bleeding
- [ ] Allergies
- [ ] Anemia
- [ ] Aortic Stenosis
- [ ] Art. Heart Valve
- [ ] Arthritis
- [ ] Artificial Joints
- [ ] Asthma
- [ ] Back Problems
- [ ] Bisphosphonates
- [ ] Blood Disease
- [ ] Blood Thinners
- [ ] Cancer
- [ ] Chemical Dependency
- [ ] Chemotherapy
- [ ] Chest Pain
- [ ] Cortisone Treatments
- [ ] Currently Pregnant
- [ ] Diabetes
- [ ] Dizziness
- [ ] Epilepsy
- [ ] Excessive Bleeding
- [ ] Fainting
- [ ] Glaucoma
- [ ] Head Injuries
- [ ] Headaches
- [ ] Heart Murmur
- [ ] Heart Problems
- [ ] Hepatitis
- [ ] Herpes
- [ ] High Blood Pressure
- [ ] HIV/ AIDS
- [ ] Infectious Disease
- [ ] Jaundice
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Low Blood Pressure
- [ ] Mental Disorders
- [ ] Mitral Valve
- [ ] Nervous Disorders
- [ ] No Epinephrine
- [ ] Osteoporosis
- [ ] Other*
- [ ] Pacemaker
- [ ] Pre-Med Needed
- [ ] Radiation Treatment
- [ ] Respiratory Problems
- [ ] Rheumatic Fever
- [ ] Sinus Problems
- [ ] Sjogren's Syndrome
- [ ] Stroke
- [ ] Taking Coumadin
- [ ] Tuberculosis
- [ ] Tumors
- [ ] Ulcers

Other*

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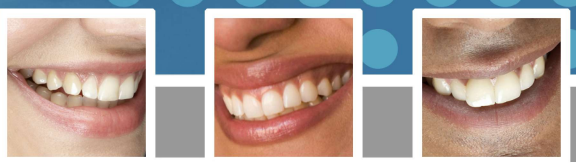

Medical History (Cont.)

Please List Allergies

Please List Medications

Height

Weight

☐ By checking this box, I acknowledge that the above information is correct and I understand it is my responsibility to inform the office of any changes in my health as soon as possible.

Response Date: