1420 E. McAndrews Rd
www.summitDMD.com

SUMMIT
FAMILY DENTAL CARE

office@summitdmd.com
541-779-2634

Patient Information

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

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

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

Email Address: _____ Best time to call: _____

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

Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Employer: _____ _____
Name Phone

Address: _____ _____
City State Zip

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?

_____

_____

Dental Insurance

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

Subscriber's Birth Date: _____ SSN#: _____ ID#: _____ Group #: _____

Subscriber's Address: _____ (Address 1) _____ (Address 2)

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

Subscriber's Employer: _____ (Name)

Employer Address: _____ (Address 1) _____ (Address 2)

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

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

Insurance Plan Name: _____

Insurance Address: _____ (Address 1) _____ (Address 2)

_____ (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.

Secondary Dental Insurance

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

Subscriber's Birth Date: _____ SSN#:_____ ID#: _____ Group #: _____

Subscriber's Address: _____ (Address 1) _____ (Address 2)

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

Subscriber's Employer: _____ (Name)

Employer Address: _____ (Address 1) _____ (Address 2)

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

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

Insurance Plan Name: _____

Insurance Address: _____ (Address 1) _____ (Address 2)

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

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? _____

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 Sweets	☐ Sensitivity to Biting
☐ Tobacco Use	☐ Tooth Pain		

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
- ☐ Marijuana Use
- ☐ Mental Disorders
- ☐ Mitral Valve
- ☐ Nervous Disorders
- ☐ No Epinephrine
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pre-Med Needed
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Sjogren's Syndrome
- ☐ Stroke
- ☐ Taking Coumadin
- ☐ Tobacco Use
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers

Other:

_____

_____

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:_____/___/_____