SUN VALLEY DENTAL GROUP
181 FIRST AVENUE, NORTH · P.O. BOX 3360
KETCHUM, IDAHO 83340 · 208-726-4711

WELCOME!

The benefits of a happy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

PATIENT INFORMATION

Name _____ Soc. Sec. # _____

How do you prefer to be addressed? _____

Address _____ Home Phone _____

Email _____ Cell Phone _____

City _____ State _____ Zip _____

Sex M ☐ F ☐ Age ____ Birthdate _____ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐

Patient Employed By _____ Occupation _____

Business Address _____ Business Phone _____

Whom May We Thank For Referring You? _____

Previous Dentist _____

Person to Notify in case of Emergency _____ Phone _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Soc. Sec. # _____ Birthdate _____

City _____ State _____ Zip _____

Person Responsible Employed By _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____

Address _____ Phone _____

Plan # _____ Group # _____

Names of Other Dependants Under this Plan _____

MEDICAL HISTORY

Do you have a personal physician? _____ Physician's Name _____

Phone # (___) _____ Date of last visit _____

Are you currently under the care of a physician? _____ Please explain _____

Your current physical health is ☐ Good ☐ Fair ☐ Poor

Do you smoke or use tobacco in any form? ☐ Yes ☐ No

Have you had any metal rods, pins, or implants? ☐ Yes ☐ No

Are you taking any prescription/over-the-counter herbal supplements?

☐ Yes ☐ No Please list each one:

_____

Have you taken Fosamex, Actonel, Boniva or any other bisphosphanate?

☐ Yes ☐ No

For Women: are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you Pregnant? ☐ Yes ☐ No Week # _____

Are you nursing? ☐ Yes ☐ No

MEDICAL HISTORY CONTINUED...

Have you ever had any of the following diseases or medical problems?

Y N Abnormal Bleeding
Y N Alcohol/Drug Abuse
Y N Anomia
Y N Arthritis
Y N Artificial Bones/Joints/Valves
Y N Asthma
Y N Blood Transfusions
Y N Cancer/Chemotherapy
Y N Colitis
Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Emphysema
Y N Epilepsy
Y N Fainting Spell
Y N Frequent Headaches
Y N Glaucoma
Y N Hay Fever
Y N Heart Attack
Y N Heart Murmr
Y N Heart Surgery
Y N Hemophilia
Y N Hepatitis
Y N Herpes/Fever Blisters
Y N High Blood Pressure
Y N HIV+/AIDS
Y N Hospitalized for Any Reason
Y N Kidney Problems
Y N Liver Disease
Y N Low Blood Pressure
Y N Lupus
Y N Mitral Valve Prolapse
Y N Osteoporosis/Paget's Disease
Y N Pacemaker
Y N Psychiatric Problems
Y N Radiation Treatment
Y N Rheumatic/Scarlet Fever
Y N Seizures
Y N Shingles
Y N Sickle Cell Disease/Traits
Y N Sinus Problems
Y N Stroke
Y N Thyroid Problems
Y N Tuberculosis (TB)
Y N Ulcers
Y N Venereal Disease

Please list any serious medical conditions you have ever had

_____

_____

_____

Are you allergic to any of the following?

Y N Aspirin
Y N Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Latex
Y N Penicillin
Y N Tetracycline
Y N Other

Please list any other drugs/materials that you are allergic to:

_____

_____

_____

DENTAL HISTORY / CARE

1. Immediate dental concerns _____

2. Do your gums bleed when you brush? _____

3. How often do you brush your teeth? _____

4. Do your gums ever feel swollen & tender? _____

5. Do sweets, hot or cold cause pain in your mouth? _____

6. Have you ever had periodontal disease? _____

7. Do you have popping/pain in your jaw? _____

8. Does food catch between your teeth? _____

9. Do you have any swelling or lumps in your mouth? _____

10. Do you grind your teeth at night? _____

11. Do you currently have any pain in your mouth? _____

12. Are you satisfied with the appearance, shape and color of your teeth? _____

Topical fluoride is the standard of care for everyone, adults & children. You will receive a fluoride treatment at every hygiene visit, unless otherwise noted. Do you wish to have fluoride treatment? _____ Yes _____ No

SMILE HISTORY

1. Do you smile with confidence? ☐ Yes ☐ No

2. Have you ever tried teeth whitening? ☐ Yes ☐ No

3. Have you ever worn braces or Invisilign? ☐ Yes ☐ No

4. Have you ever had a professional smile consultation? ☐ Yes ☐ No

_____
Signature Date

We're glad you're here! We'll take good care of you!