8196 Colorado Blvd. Ste #10
Firestone, CO 80504
P: 303-833-5660 F: 303-833-5661

LONGS PEAK DENTISTRY

Patient Information:

Full Name:(F)__________(M)__________(L)__________
Date of Birth__________SSN__________
Mailing Address__________City__________State______Zip__________
Home Phone__________Work Phone__________Cell Phone__________
Email__________How did you find us?__________
Minor___Single___Married___Divorced___Widowed___
Patient or Parents Employer__________
Business Address__________City:__________State:______Zip:__________
Spouse or Parents Name__________ If Student-Name of School__________
In case of emergency contact__________Phone:__________
How would you like to be contacted? Circle one E-mail Text Home Cell Work Phone

Responsible party:

Name of Responsible Party__________Relationship to Patient__________
Address__________City__________State______Zip__________
Date of Birth__________SSN__________
Employer and Address__________

Primary Insurance Information:

Name of Insured__________Relationship to Patient__________
Address__________City__________State______Zip__________
Date of Birth__________SSN__________
Employer and Address__________
Insurance Company__________Group #__________Phone__________
Address__________City__________State______Zip__________

Secondary Insurance Information:

Name of Insured__________Relationship to Patient__________
Address__________City__________State______Zip__________
Date of Birth__________SSN__________
Employer and Address__________
Insurance Company__________Group #__________Phone__________
Address__________City__________State______Zip__________

Medical History:

Physician's Name__________Phone________Date of last exam__________

	No	Yes
Are you under the care of a physician?-------------------------------------	☐	☐
Have you been hospitalized for surgery or illness?----------------------	☐	☐
Are you taking over the counter or prescription medications?----------	☐	☐

Please List:__________

____

____

	No	Yes
Do you use tobacco? -------------------------------------	☐	☐
Do you use alcohol? --------------------------------------	☐	☐
Do you use recreational drugs? ------------------------	☐	☐
Have you ever had a reaction to local anesthetic?--	☐	☐
Do you wear contact lenses?---------------------------	☐	☐

Women Only:

Are you pregnant?__________
Are you nursing?__________
Are you taking BCP?__________
Date of last exam?__________

	No	Yes
Do you have allergies? Drugs or Food?---------------	☐	☐

Please List:____

Which of the following apply? Check only if yes.

☐High blood pressure	☐Frequently tired	☐Aids/HIV
☐Heart attack	☐Anemia	☐STD's
☐Rheumatic Fever	☐Emphysema	☐Thyroid problems
☐Swollen ankles	☐Cancer	☐Hepatitis A, B, C
☐Fainting	☐Arthritis	☐Ulcers
☐Seizures	☐Joint Replacement	☐Respiratory problems
☐Asthma	☐Chest pains	☐Osteoporosis
☐Low blood pressure	☐Short of Breath	☐Bleeding disorders
☐Epilepsy/Convulsions	☐Stroke	☐Other______________________
☐Leukemia	☐Hay fever/Allergies	______________________
☐Diabetes	☐Tuberculosis	______________________
☐Heart Disease	☐Radiation Therapy	______________________
☐Cardiac Pacemaker	☐Glaucoma	______________________
☐Heart Murmur	☐Liver Disease	______________________
☐Angina	☐Kidney Disease	______________________

Dental History: **Check No or Yes**

	No	Yes
Do your gums bleed while flossing/brushing?---------------	☐	☐
Are your teeth sensitive to hot/cold liquids/foods?----------	☐	☐
Are your teeth sensitive to sweet/sour liquids/foods?------	☐	☐
Do you feel pain in any of your teeth?------------------------	☐	☐
Do you have sores or lumps in your mouth?----------------	☐	☐
Have you ever had trauma to your face, mouth or jaw?---	☐	☐
Does your jaw click, pop, crackle or ache?------------------	☐	☐
Do you have difficulty opening or closing you mouth?-----	☐	☐
Do you have difficulty chewing?--------------------------------	☐	☐
Do you have frequent headaches?----------------------------	☐	☐
Do you clench or grind you teeth?----------------------------	☐	☐
Do you bite your lips or cheeks frequently?------------------	☐	☐
Have you had problems with previous dental work?-------	☐	☐
Have you ever had braces? -----------------------------------	☐	☐
How many times a day do you brush?--------------------	______	
How many times a day do you floss?---------------------	______	
Do you use an electric brush?-------------------------------	☐	☐
Do you use any mouth rinses?--------------------------------	☐	☐
Have you ever been told you have Periodontal Disease?	☐	☐

Blood Pressure______________

Pulse______________

Date of Last Visit______________

Goals for your mouth and teeth?____________________________________

If you could change anything about your smile, what would that be?____________________

____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been answered accurately. I understand that providing false or incorrect information can be dangerous to my health.

X______________________________
Patient or guardian signature Date

____
Dentist Signature Date

X______________________________
Print Name Date

____
Witness Signature Date