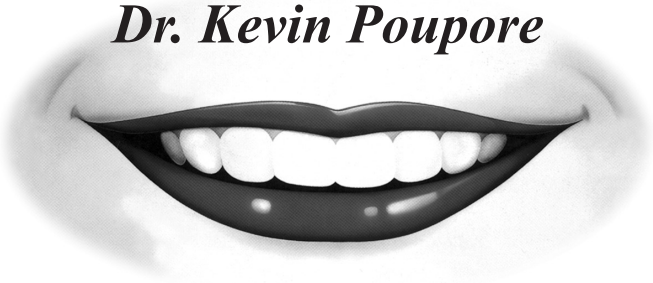
Dr. Kevin Poupore



Cosmetic & Sedation Dentistry

Adult Patient Form

Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Medical History

Physician's Name:_____ Phone: _____

Date of last visit:_____ Have you had any serious illnesses or operations? ☐ Yes ☐ No

If yes, describe: _____

Are you currently under physician care? ☐ Yes ☐ No

If yes, describe: _____

Women: Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check if you have had problems with any of the following:

☐ Abnormal Bleeding	☐ Circulatory Problems	☐ High Blood Pressure	☐ Rheumatic Fever
☐ AIDS/HIV Positive	☐ Diabetes	☐ Jaw Pain	☐ Shortness/Breath
☐ Anaphylaxis	☐ Epilepsy	☐ Kidney Disease	☐ Stroke
☐ Anemia	☐ Fainting	☐ Latex Allergies	☐ Surgical Implant
☐ Arthritis Rheumatism	☐ Glaucoma	☐ Liver Disease	☐ Swelling of Feet/Ankles
☐ Artificial Heart Valves	☐ Headaches	☐ Low Blood Pressure	☐ Thyroid Disease
☐ Artificial Joints Hips/Knee	☐ Heart Murmur	☐ Mitral Valve Prolapse	☐ Tobacco Habit
☐ Asthma	☐ Heart Problems	☐ Nervous Problems	☐ Tuberculosis
☐ Back Problems	☐ Heart Surgery	☐ Pacemaker	☐ Ulcer/Colitis
☐ Cancer	☐ Hepatitis	☐ Radiation Treatment	☐ Venereal Disease
☐ Chemotherapy	☐ Herpes	☐ Respiratory Disease	

Please list all the medications you are currently taking:

Please list all your allergies:

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance form 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 charges whether or not paid by insurance.

Signature:_____ **Date:**_____

Payment is due in full at time of treatment, unless prior arrangements have been approved.

Patient Information

Patient Name:_____ Date:_____

Social Security #:_____ Birth Date: _____

Gender (M/F):_____ Marital Status: _____

Address: _____

Occupation:_____ Employer: _____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Email: _____

Insurance Information

Primary:

Name of Insured:_____ Relation: ☐ Self ☐ Spouse ☐ Child ☐ Other

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

Insured's Address:_____

Insured's Employer Name: _____

Insurance Plan Name: _____

Insurance Plan Address: _____

Secondary:

Name of Insured:_____ Relation: ☐ Self ☐ Spouse ☐ Child ☐ Other

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

Insured's Address:_____

Insured's Employer Name: _____

Insurance Plan Name: _____

Insurance Plan Address: _____

Referral Information

Whom may we thank for referring you to our practice? ☐ Another Patient ☐ Friend/Relative ☐ Dental Office ☐ Church Bulletin ☐ Yellow Pages ☐ Newspaper ☐ Billboard ☐ Postcard ☐ Radio ☐ Website ☐ Other: _____

Name of person or office referring you to our practice: _____

Dental History

Date of last dental care:_____ Date of last x-rays: _____

Former dentist _____

How often do you brush?_____ How often do you floss?_____

How do you feel about the appearance of your teeth? _____

Check if you have had problems with any of the following:

☐ Bad Breath	☐ Grinding or Clenched Teeth	☐ Sensitivity to Hot
☐ Bleeding Gums	☐ Loose Teeth or Broken Fillings	☐ Sensitivity to Sweets
☐ Clicking or Popping Jaw	☐ Periodontal Treatment	☐ Sensitivity When Biting
☐ Food Collection Between Teeth	☐ Sensitivity to Cold	☐ Sores or Growths in Mouth

What would you like us to do today? _____

Are you in dental discomfort today?_____

Other information about your dental health or previous treatment?_____