ROCK HOTEL DENTAL, LLC

PATIENT INFORMATION

88 East State Street • P.O. Box 220 • Farmington, Utah 84025

Name: _____ Preferred Name: _____

Birthdate: _____ SS #: _____ email: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Who referred you to our office? _____

Name & Phone Number of closest relative: _____

"I consent to receive calls from (Rock Hotel Dental) for my protected healthcare and other services at the phone number(s) above, including my wireless number provided. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

RESPONSIBLE PARTY / INSURANCE INFORMATION

Name / Insured: _____ Birthdate: _____ Social Security #: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Employer: _____ Group #: _____ Subscriber #: _____

Insurance Company: _____ Phone #: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

As a courtesy, Rock Hotel Dental will file your dental insurance claim and do our best to maximize your benefits available.
Please understand that it is the resposibility of the patient to know their benefits. Any services not covered by your plan will be your financial responsibility.

SECONDARY INSURANCE

Name / Insured: _____ Birthdate: _____ Social Security #: _____

Insurance Company: _____ Group #: _____

Phone #: _____ Subscriber #: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

DENTAL HISTORY

1. Have you ever had any adverse reactions with dental treatment? Please Explain: _____

2. Have ever had any adverse reactions with any of the following during dental treatment?
   ☐ Local Anesthetic (i.e. lidocaine, epinephrine) ☐ Nitrous Oxide ☐ Bleeding Problems ☐ Anxiety ☐ Other
   If yes to any of the above, please explain. _____
3. Do you prefer nitrous oxide (laughing gas) analgesia? ☐ Yes ☐ No ☐ Haven't Tried It
4. Date of last dental treatment: _____
5. Have you ever been treated for periodontal disease? (pyorrhea, gum disease, trench mouth)
   ☐ Yes ☐ No If yes, when? _____
6. Do you use tobacco? ☐ Yes ☐ No ☐ Cigarettes ☐ Pipe or Other ☐ Smokeless ☐ E-Cigarettes
7. Do you use the following? Check all that apply:
   ☐ Soft Toothbrush ☐ Dental Floss ☐ Oral Irrigating Device ☐ Periodontal Aids
   ☐ Medium/Hard Toothbrush ☐ Fluoride Rinse ☐ Saliva Substitute ☐ Other
   ☐ Electric Toothbrush ☐ Fluoride Tablets ☐ Toothpick
8. Are there any problems or conditions you want us to be aware of? _____

MEDICAL HISTORY

1. Are you in Good Health? ☐ Yes ☐ No Name of Medical Doctor: _____
2. Are you now under a physician's care? ☐ Yes ☐ No Reason: _____
3. Have you been hospitalized, had a serious illness or major surgery? ☐ Yes ☐ No Reason: _____

_____

4. (WOMEN) Are you pregnant? ☐ Yes ☐ No Due Date: _____ Nursing? ☐ Yes ☐ No
5. Have you ever had an artificial joint? ☐ Yes ☐ No If yes. Which joint was replaced? _____

When: _____ Surgeon / Dr.'s Name: _____

Since this surgery, has your Surgeon or Dr. recommended that you take antibiotic premedication prior to dental work or cleanings? ☐ Yes ☐ No

6. Do you have any cardiac condition or any other medical conditions that your Dr. or Surgeon has recommended antibiotic premedication prior to dental work or cleanings? ☐ Yes ☐ No

If yes, please explain your condition.

_____

Surgeon / Dr.'s Name _____

7. Do you have, or have you ever had any of the following? Check all that apply:

- ☐ Rheumatic Fever
- ☐ Infective Endocarditis
- ☐ Mitral Valve Prolapse
- ☐ Artificial Heart Valves
- ☐ Heart Murmur
- ☐ Heart Attack
- ☐ Heart Surgery
- ☐ Chest Pain / Angina
- ☐ Pacemaker
- ☐ Congenital Heart Defect
  - ☐ Fully Repaired
  - ☐ Unrepaired
- ☐ High Blood Pressure
- ☐ Anemia
- ☐ High Cholesterol
- ☐ Stroke
- ☐ Sleep Apnea
- ☐ Diabetes; Type I Type II
- ☐ Hypoglycemia
- ☐ Bleeding Disorder
- ☐ Hemophilia
- ☐ Artificial Joint Replacement
- ☐ Organ Transplant
- ☐ Eating Disorder
- ☐ Tuberculosis
- ☐ Emphysema / Shortness of Breath
- ☐ Asthma
- ☐ Hay Fever
- ☐ Sinus Problem
- ☐ Thyroid Condition / Goiter
- ☐ Cancer
  - ☐ Radiation
  - ☐ Chemotherapy
- ☐ Tumors / Growths
- ☐ Kidney Disease
- ☐ Venereal Disease / STD
- ☐ Aids / HIV positive
- ☐ Birth Defects
- ☐ Psychiatric Disorder
- ☐ Depression
- ☐ Seizures / Convulsions/Epilepsy
- ☐ Liver Disease
- ☐ Hepatitis / Jaundice
- ☐ G.E Reflux / Persistent Heartburn
- ☐ Ulcers
- ☐ Gout
- ☐ Tire Easily / Weakness
- ☐ Dizziness / Fainting
- ☐ Numbness / Tingling
- ☐ Marked Weight Change
- ☐ Loss of Hearing
- ☐ Ringing of the Ears
- ☐ Persistent Headaches / Migraines
- ☐ Persistent Fever
- ☐ Skin Rash / Hives
- ☐ Difficulty Healing After a Cut
- ☐ Persistent Sore Throat
- ☐ Bruise Easily
- ☐ Arthritis
- ☐ Lupus Erythematosus
- ☐ Other Auto-Immune Disorder
- ☐ Osteoporosis
- ☐ Chronic Pain
- ☐ Back Problems
- ☐ Autism
- ☐ Neurological Disorder
- ☐ Other
- ☐ None

8. Are you allergic or have you had any reaction to any of the following?

- ☐ Local Anesthetic
- ☐ Aspirin
- ☐ Penicillin
- ☐ Other Antibiotics
- ☐ Codeine
- ☐ Other Narcotics
- ☐ Sulfa Drugs
- ☐ Barbiturates / Sedatives
- ☐ Latex
- ☐ Metals
- ☐ Coloring
- ☐ Flavorings
- ☐ Iodine
- ☐ Gluten
- ☐ Foods
- ☐ Other
- ☐ None

9. Are you currently taking any of the following medication?

- ☐ Antibiotics
- ☐ Heart Medication
- ☐ Nitroglycerin
- ☐ Blood Pressure Medication
- ☐ Blood Thinners
- ☐ High Cholesterol
- ☐ Other
- ☐ Insulin / Diabetes Medication
- ☐ Cortisone / Steroids
- ☐ Arthritis Medication
- ☐ Aspirin
- ☐ Hormone Therapy
- ☐ Birth Control
- ☐ Thyroid
- ☐ Anti Depressants
- ☐ Tranquilizers
- ☐ Dilantin / Seizure Medication
- ☐ Osteoporosis Med / IV or Oral
- ☐ Acid Reflux Medication
- ☐ Pain Medication
- ☐ Allergy / Cold Medication
- ☐ Acne Medication
- ☐ Recreational Drugs
- ☐ None

Updates: _____

_____

_____

_____

To the best of my knowledge, all of the preceding answers are true and correct. I agree to notify the dentist of any changes in my health or my medication. I understand that chemical interactions can not be prevented if the dentist is unaware of the drugs I use.

_____ _____