desert smiles
COSMETIC + RESTORATIVE DENTISTRY

Nathan P. Tenney, D.M.D.
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PATIENT INFORMATION

Patient Name: _____ ☐ Male ☐ Female

Date of Birth: _____/_____/_____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed SS#: _____

Patient Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

Email: _____ Work Phone: _____

_____ I give my permission for Desert Smiles to leave text messages, voice mails or emails regarding my treatment for upcoming appointments.
Initial

Person Responsible for this account: _____

If under 18, parent's or legal guardian's name: _____

In Case of Emergency, who should we notify?: _____ Phone: _____

Who may we thank for referring you? _____

Please provide name of Primary Care Physician (PCP): _____

PCP's Phone: _____

What is your preferred Pharmacy?: _____

Pharmacy Phone: _____ Cross Streets: _____

INSURANCE INFORMATION

Insured's Employer: _____ Insured's Insurance Carrier: _____

Policy Holder: _____ Date of Birth: _____ /_____ /_____ Group #: _____

Insurance ID# or SS#: _____

Secondary Insurance Employer: _____ Insured's Insurance Carrier: _____

Policy Holder: _____ Date of Birth: _____ /_____ /_____ Group #: _____

Insurance ID# or SS#: _____

ASSIGNMENT AND RELEASE OF BENEFITS

I grant authority to Nathan P. Tenney, D.M.D. to perform dental and surgical procedures and treatments, including the administration of medicines and local anesthetics that are deemed necessary and advisable for this patient. Patient and/or legal guardian/parent will be informed before any treatment is performed.
I authorize the release of any information necessary to expedite insurance claims, I understand that I am ultimately responsible for ANY and ALL charges, regardless of insurance coverage.
I hereby certify the above to be true and correct to the best of my knowledge.

Signed: _____ Date: _____

Please continue on back ⟶

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HEALTH HISTORY

Patient Name _____ Date of Birth _____

What brought you here today? _____

How long since your last dental visit? _____

Have you had dental complications in the past? ☐ Yes ☐ No If yes _____

Have you ever been treated for gum disease? ☐ Yes ☐ No If yes _____

Do you have clicking or popping in your jaw? ☐ Yes ☐ No If yes _____

Do you clench or grind your teeth? ☐ Yes ☐ No

Do you have TMJ / TMD? ☐ Yes ☐ No If yes _____

Is there anything you would change about the appearance of your teeth or smile? ☐ Yes ☐ No If yes _____

Are you currently pregnant? ☐ Yes ☐ No Are you currently taking oral contraceptives? ☐ Yes ☐ No

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No If yes _____

Has a physician recommended you take a Pre-Medication (antibiotics) for dental treatment? ☐ Yes ☐ No If yes _____

Have you ever had a reaction after receiving dental anesthetic? ☐ Yes ☐ No Explain reaction: _____

Have you had any medical procedures since your last visit? ☐ Yes ☐ No For what condition? _____

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other: ☐ If yes _____

Are you interested in learning more about Botox or Dermal fillers for pain management or cosmetic reasons? ☐ Yes ☐ No

Do you use controlled substances or tobacco? ☐ Yes ☐ No if yes, what type: ☐ Cigarettes ☐ Vape ☐ Cigar ☐ Chewing Tobacco

Do you have, or have you had, any of the following?

AIDS/HIV Positive ☐ Yes ☐ No	Cortisone Medicine ☐ Yes ☐ No	Hepatitis A, B, C ☐ Yes ☐ No	Rheumatic Fever ☐ Yes ☐ No
Alzheimer's Disease ☐ Yes ☐ No	Diabetes ☐ Yes ☐ No	Herpes ☐ Yes ☐ No	Rheumatism ☐ Yes ☐ No
Anaphylaxis ☐ Yes ☐ No	Drug Addiction ☐ Yes ☐ No	High Blood Pressure ☐ Yes ☐ No	Scarlet Fever ☐ Yes ☐ No
Anemia ☐ Yes ☐ No	Easily Winded ☐ Yes ☐ No	High Cholesterol ☐ Yes ☐ No	Shingles ☐ Yes ☐ No
Angina ☐ Yes ☐ No	Emphysema ☐ Yes ☐ No	Hives or Rash ☐ Yes ☐ No	Sickle Cell Disease ☐ Yes ☐ No
Arthritis/Gout ☐ Yes ☐ No	Epilepsy or Seizures ☐ Yes ☐ No	Hypoglycemia ☐ Yes ☐ No	Sinus Trouble ☐ Yes ☐ No
Artificial Heart Valve ☐ Yes ☐ No	Excessive Bleeding ☐ Yes ☐ No	Irregular Heartbeat ☐ Yes ☐ No	Sleep Apnea ☐ Yes ☐ No
Artificial Joint ☐ Yes ☐ No	Excessive Thirst ☐ Yes ☐ No	Kidney Problems ☐ Yes ☐ No	Spina Bifida ☐ Yes ☐ No
Asthma ☐ Yes ☐ No	Fainting Spells/Dizziness ☐ Yes ☐ No	Leukemia ☐ Yes ☐ No	Stomach/Intestinal Disease ☐ Yes ☐ No
Blood Transfusion ☐ Yes ☐ No	Frequent Cough ☐ Yes ☐ No	Liver Disease ☐ Yes ☐ No	Stroke ☐ Yes ☐ No
Braces ☐ Yes ☐ No	Frequent Headaches ☐ Yes ☐ No	Low Blood Pressure ☐ Yes ☐ No	Swelling of Limbs ☐ Yes ☐ No
Breathing Problems ☐ Yes ☐ No	Glaucoma ☐ Yes ☐ No	Lung Disease ☐ Yes ☐ No	Thyroid Disease ☐ Yes ☐ No
Bruise Easily ☐ Yes ☐ No	Hay Fever ☐ Yes ☐ No	Mitral Valve Prolapse ☐ Yes ☐ No	Tonsillitis ☐ Yes ☐ No
Cancer ☐ Yes ☐ No	Hearing Impairment ☐ Yes ☐ No	Osteoporosis ☐ Yes ☐ No	Tuberculosis ☐ Yes ☐ No
Chemotherapy ☐ Yes ☐ No	Heart Attack/Failure ☐ Yes ☐ No	Pain in Jaw Joints ☐ Yes ☐ No	Tumors or Growths ☐ Yes ☐ No
Chest Pains ☐ Yes ☐ No	Heart Murmur ☐ Yes ☐ No	Parathyroid Disease ☐ Yes ☐ No	Ulcers ☐ Yes ☐ No
Cold Sores/Fever Blisters ☐ Yes ☐ No	Heart Pacemaker ☐ Yes ☐ No	Psychiatric Care ☐ Yes ☐ No	Venereal Disease ☐ Yes ☐ No
Congenital Heart Disorder ☐ Yes ☐ No	Heart Trouble/Disease ☐ Yes ☐ No	Radiation Treatments ☐ Yes ☐ No	Yellow Jaundice ☐ Yes ☐ No
Convulsions ☐ Yes ☐ No	Hemophilia ☐ Yes ☐ No	Renal Dialysis ☐ Yes ☐ No	

Please list any medical conditions we should know that are not listed above: _____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDING HERBAL MEDICATIONS, VITAMINS & SUPPLEMENTS):

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

I understand that providing incorrect information can be dangerous to my (or patient's) health.

Signature _____ Date _____

☐ Adult Patient ☐ Parent or Guardian ☐ Spouse