Broadmoor Valley Dental Care

OLIVER M. SPAETH, DDS

Patient-centered dentistry for healthy, beautiful smiles

Patient Information

Date _____

Name: _____ ☐ MARRIED ☐ SINGLE ☐ MINOR ☐ MALE ☐ FEMALE
LAST FIRST M

Social Security #: _____

Address: _____
STREET APT.# CITY STATE ZIP

Birth date: _____ Telephone: _____ _____ _____
M/D/Y HOME WORK MOBILE

E-mail: _____ Electronic reminders, do you prefer ☐ text ☐ email

Name of Employer: _____ Address: _____

Person Responsible for account- Please Check One: ☐ PATIENT ☐ GUARDIAN ☐ SPOUSE ☐ FATHER ☐ MOTHER

Insurance Information

Minor Child - May need to complete both blocks for patient information
Adults- Complete primary insured
Dual Coverage? Also Complete Secondary Insured

Primary Insured/ If no insurance complete for responsible party

Last First M

Street

City State Zip

Home Work Cell

E-Mail

Birthdate (M/D/Y) Relationship to patient

Employer Dental Ins Co

SS# Subscriber #

Group#

Secondary Insured

Last First M

Street

City State Zip

Home Work Cell

E-Mail

Birthdate (M/D/Y) Relationship to patient

Employer Dental Ins Co

SS# Subscriber #

Group#

Person to Contact in Case of Emergency

Name: _____ Telephone: _____

Has any member of your family ever been treated in our office? ☐ Yes ☐ No

Whom may we thank for referring you to our office? _____

Primary reason for this dental appointment: ☐ Examination ☐ Emergency ☐ Consultation

Dental History

	Yes	No
Do you have a specific dental problem? Describe:	☐	☐
Do you have dental examinations on a routine basis? When was your last visit?	☐	☐
Do you think you have active decay or gum disease?	☐	☐
Do you brush and floss on a routine basis? Discuss	☐	☐
Do your gums ever bleed? Discuss	☐	☐
Do you like your smile? Why?	☐	☐
Does food catch between your teeth? Any loose teeth?	☐	☐
Do you want to keep your remaining teeth?	☐	☐
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind?	☐	☐
Have your past experiences in a dental office always been positive?	☐	☐
Do you smoke or chew? Any sores or growth in your mouth? Discuss	☐	☐

Name of previous dentist (optional) _____

Date of last full mouth x-rays (16 small films or panoramic): _____

Medical History

	Yes	No
Are you under a physician's care now? Why? Who? _____ Phone _____	☐	☐
Have you ever been hospitalized or had a major operation? Discuss	☐	☐
Have you ever had a serious injury to your head or neck? Discuss	☐	☐
Are you taking any medications, aspirin, vitamins, herbals, pills or drugs? What?	☐	☐
Are you on a special diet? Discuss	☐	☐
Are you allergic to any medications or substances? Please check box below	☐	☐

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex Rubber ☐ Metal ☐ Other

Women (Please Check):

☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives

Discuss _____

Do you now have or have you ever had any of the following? Do you take any of these medicines? Please check appropriate boxes.
*If yes to any of the starred conditions, please call prior to your appointment... pre medication or changes in medication may be required.

	Yes	No		Yes	No		Yes	No
Heart Disease/Surgery *	☐	☐	Sinus Trouble	☐	☐	Arthritis/Gout	☐	☐
Heart Murmur or Defect*	☐	☐	Asthma	☐	☐	Rheumatism	☐	☐
Irregular Heart Beat	☐	☐	Bloody Sputum	☐	☐	Pain in Jaw Joints	☐	☐
Angina/Chest Pain	☐	☐	Emphysema	☐	☐	Cortisone Medicine	☐	☐
Heart Attack/Failure	☐	☐	Tuberculosis	☐	☐	Artificial Joint*	☐	☐
Congenital Hear Disorder*	☐	☐	Cancer	☐	☐	Sexually Transmitted Disease	☐	☐
Mitral Valve Prolapse*	☐	☐	X-Ray Treatments (Radiation)	☐	☐	Aids	☐	☐
Scarlet Fever	☐	☐	Chemotherapy	☐	☐	HIV Positive	☐	☐
Rheumatic Fever*	☐	☐	Osteoporosis	☐	☐	Genital Herpes	☐	☐
Artificial Heart Valve*	☐	☐	Bisphosphonates	☐	☐	Drug Addiction/Alcoholism	☐	☐
Heart Pace Maker	☐	☐	Osteonecrosis of Jaw	☐	☐	Tattoos/Body Piercing	☐	☐
Pulmonary Shunt*	☐	☐	Aredia I.V. Reclast I.V.	☐	☐	Sleep Apnea	☐	☐
High Blood Pressure	☐	☐	Zometa I.V.	☐	☐	Cold Sores	☐	☐
Low Blood Pressure	☐	☐	Fosamax, Actonel, Boniva	☐	☐	Fever Blisters	☐	☐
Bacterial Endocarditis	☐	☐	Stomach/Intestinal Disease	☐	☐	Herpes	☐	☐
Unexplained Fever	☐	☐	Ulcers	☐	☐	Stroke	☐	☐
Bruise Easily/Blood Disease	☐	☐	Recent Weight Loss	☐	☐	Convulsions	☐	☐
Anemia	☐	☐	Frequent Diarrhea	☐	☐	Epilepsy or Seizures	☐	☐
Coronary Stent*	☐	☐	Diabetes	☐	☐	Fainting or Dizziness	☐	☐
Excessive Bleeding	☐	☐	Excessive Thirst	☐	☐	Glaucoma	☐	☐
Sickle Cell Disease	☐	☐	Hypoglycemia	☐	☐	Tumors or Growths	☐	☐
Hemophilia	☐	☐	Liver Disease	☐	☐	Nervousness	☐	☐
Methemoglobinemia	☐	☐	Hepatitis A (Infectious)	☐	☐	Psychiatric Care	☐	☐
Leukemia	☐	☐	Hepatitis B or C	☐	☐	Alzheimer's Disease	☐	☐
Recent Blood Transfusion	☐	☐	Protease Inhibitor	☐	☐	Allergies (Medicines)	☐	☐
Swelling of Limbs	☐	☐	Night Sweats	☐	☐	Allergens (Pollen / Dust)	☐	☐
Lung Disease	☐	☐	Yellow Jaundice	☐	☐	Hives or Rash	☐	☐
Breathing Problem	☐	☐	Kidney Problems	☐	☐	Need Pre medication	☐	☐
Shortness of Breath	☐	☐	Renal Dialysis	☐	☐	Ever taken fen-phen?*	☐	☐
Frequent Cough	☐	☐	Thyroid Disease	☐	☐	Cochlear implants?	☐	☐
Hay Fever	☐	☐	Parathyroid Disease	☐	☐			

Have you ever had any other serious illness not checked above? Discuss	☐	☐
Do you wish to talk to the dentist privately about any problem?	☐	☐

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

Patient Name: _____ Date: _____

Email Form Please email this form with our email button or save the file and email to info@bvdc.net.