



Patient Information

(Confidential)

Dale D. Batten, DMD, PA

Comprehensive Dentistry

Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, don't hesitate to ask for assistance. We will be happy to help.

(Please Print)

Name _____ SS# _____
First Middle Last

Address: _____ City _____ State _____ Zip _____

Sex: Female Male Birth date: _____ E-mail: _____

Home Phone () _____ Cell Phone () _____ Work Phone () _____

Do you prefer to receive calls at: Home Work Cell No Preference

Married Widowed Single Separated Divorced Partnered for ____ years

Patient Employer / School _____ Occupation _____

Employers / School Address _____ City _____ State _____ Zip _____

Spouse/Parent Name _____ Employer _____

Who may we thank for referring you to us? _____

Person to contact in case of emergency: _____ Phone () _____

Responsible Party

Name of person responsible for this account _____

Relationship to patient _____ Phone () _____

Address _____ City _____ State _____ Zip _____

Name of Employer _____ Work Phone () _____

Dental Insurance Information

Name of Insured _____ Relationship to patient _____

Birth date _____ Social Security # _____ Date Employed _____

Name of Employer _____ Work Phone () _____

Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Group # _____ Employer # _____

Insurance Co. Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ Benefits used YTD _____ Max Annual Benefit _____

DO YOU HAVE ADDITIONAL INSURANCE? No Yes IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to patient _____

Insured Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____ Work Phone () _____

Address _____

City _____ State _____ Zip _____

Insurance Co. _____ Group # _____

Insurance Co Address _____ Employer # _____

City _____ State _____ Zip _____

How much is your deductible? _____ Benefits used YTD _____ Max Annual Benefit _____



Dental History

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Name _____ Age _____ Date of last exam _____

Previous Dentist _____ Date of last Dental X-Ray _____

What is your immediate concern? _____

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

How often do you get your teeth cleaned? 3 Mo. 4 Mo. 6 Mo. 1 Yr or longer

Do you have dental implants? How long have you had them? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

YES NO Comments

- | | | | |
|---|--------------------------|--------------------------|--|
| 1. Unhappy with the appearance of your teeth | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2. Unfavorable dental experience | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3. Dental fears | <input type="checkbox"/> | <input type="checkbox"/> | |
| 4. Problems with effectiveness or bad reaction to dental anesthetic | <input type="checkbox"/> | <input type="checkbox"/> | |
| 5. Orthodontic treatment (braces) when: | <input type="checkbox"/> | <input type="checkbox"/> | |
| 6. Periodontal (gum) treatment when: | <input type="checkbox"/> | <input type="checkbox"/> | |
| 7. Food collection between teeth | <input type="checkbox"/> | <input type="checkbox"/> | |
| 8. Bleeding gums | <input type="checkbox"/> | <input type="checkbox"/> | |
| 9. Avoid brushing any part of your mouth | <input type="checkbox"/> | <input type="checkbox"/> | |
| 10. Part of your mouth is sensitive to temperature | <input type="checkbox"/> | <input type="checkbox"/> | |
| 11. Sore teeth | <input type="checkbox"/> | <input type="checkbox"/> | |
| 12. A burning sensation in your mouth | <input type="checkbox"/> | <input type="checkbox"/> | |
| 13. Difficulty swallowing | <input type="checkbox"/> | <input type="checkbox"/> | |
| 14. An unpleasant taste in your mouth | <input type="checkbox"/> | <input type="checkbox"/> | |
| 15. Dry mouth, throat, and or eyes | <input type="checkbox"/> | <input type="checkbox"/> | |
| 16. Jaw problems (tempromandibular joint) | <input type="checkbox"/> | <input type="checkbox"/> | |
| 17. Difficulty opening your mouth widely | <input type="checkbox"/> | <input type="checkbox"/> | |
| 18. Stiff neck muscles | <input type="checkbox"/> | <input type="checkbox"/> | |
| 19. Awakened with an awareness of your teeth or jaws | <input type="checkbox"/> | <input type="checkbox"/> | |
| 20. Tension headaches | <input type="checkbox"/> | <input type="checkbox"/> | |
| 21. Clench or grind your teeth | <input type="checkbox"/> | <input type="checkbox"/> | |
| 22. Jaw clicking or popping | <input type="checkbox"/> | <input type="checkbox"/> | |

SUPPLEMENTAL DENTURE HISTORY:

If you are wearing removable complete or partial dentures, please complete the following:

- | | | |
|--------------------------|--------------------------|--|
| Yes | No | (Please check Yes or No) |
| <input type="checkbox"/> | <input type="checkbox"/> | Has your present denture been relined? When? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Is your present denture a problem? Describe: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Satisfied with the appearance? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Satisfied with the comfort? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Satisfied with the chewing ability? _____ |

When did you receive your first partial or complete denture? _____

How long have you worn your present denture? _____

Patient Signature _____ Date: _____

Doctors Signature _____ Date: _____

Remarks: _____



Medical History

Dale D. Batten, DMD, PA Comprehensive Dentistry

Patient's Name: _____ Age: _____

Please list all medications you are currently taking: _____

Allergies: Penicillin Aspirin Local Anesthetic Latex Metals Sulfa Codeine Other

Please list any other allergies: _____

(Women) Are you pregnant Yes No Nursing Yes No Taking birth control pills Yes No

What is the estimate of your general health? Poor Fair Good

Please check if you have had any of the following:

- | | | | |
|--|---|---|--|
| Y / N | Y / N | Y / N | Y / N |
| <input type="checkbox"/> <input type="checkbox"/> AIDS | <input type="checkbox"/> <input type="checkbox"/> Congenital Heart Lesion | <input type="checkbox"/> <input type="checkbox"/> Hepatitis (type___) | <input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> <input type="checkbox"/> Anemia | <input type="checkbox"/> <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> <input type="checkbox"/> Hernia Repair | <input type="checkbox"/> <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> <input type="checkbox"/> Cough up Blood | <input type="checkbox"/> <input type="checkbox"/> HIV Positive | <input type="checkbox"/> <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> <input type="checkbox"/> Diabetes | <input type="checkbox"/> <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> <input type="checkbox"/> Stroke |
| <input type="checkbox"/> <input type="checkbox"/> Asthma | <input type="checkbox"/> <input type="checkbox"/> Epilepsy | <input type="checkbox"/> <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> <input type="checkbox"/> Swelling of feet / Ankle |
| <input type="checkbox"/> <input type="checkbox"/> Back Problems | <input type="checkbox"/> <input type="checkbox"/> Fainting | <input type="checkbox"/> <input type="checkbox"/> Liver Disease | <input type="checkbox"/> <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> <input type="checkbox"/> Bleeding Abnormally | <input type="checkbox"/> <input type="checkbox"/> Glaucoma | <input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> <input type="checkbox"/> Tobacco habits |
| <input type="checkbox"/> <input type="checkbox"/> Blood Disease | <input type="checkbox"/> <input type="checkbox"/> Headaches | <input type="checkbox"/> <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> <input type="checkbox"/> Cancer | <input type="checkbox"/> <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> <input type="checkbox"/> Pacemaker | <input type="checkbox"/> <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> <input type="checkbox"/> Heart Problems | <input type="checkbox"/> <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> <input type="checkbox"/> Chemotherapy | Describe: _____ | <input type="checkbox"/> <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> <input type="checkbox"/> Hemophilia | <input type="checkbox"/> <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> <input type="checkbox"/> Drug alcohol dependency |

Have you ever taken any of these medications?

- | | | | | |
|--|-----------------------------------|-----------------------------------|----------------------------------|---------------------------------|
| Bisphosphonates/
(for osteoporosis) | <input type="checkbox"/> Actonel | <input type="checkbox"/> Fosamax | <input type="checkbox"/> Bonivia | <input type="checkbox"/> Aredia |
| | <input type="checkbox"/> Bonefox | <input type="checkbox"/> Didronel | <input type="checkbox"/> Zometa | <input type="checkbox"/> other |
| Blood Thinners: | <input type="checkbox"/> Coumadin | <input type="checkbox"/> Warfarin | | |

Please describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment:

Certification, Assignment and Release

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child ever have a change in health.

I certify that if I and/or my dependant(s), have insurance coverage, I assign directly to Dale D. Batten, DMD, PA all insurance benefits, if any, and otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions.

The above named doctor may use my healthcare information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services or referring doctors offices.

In consideration of the services rendered to me by this dental office I am obligated to pay said office in accordance with its credit terms and policies. .

I consent to the making of videotapes, photographs and x-rays before during and after treatment, and to the use of same by the doctor in scientific papers, marketing or demonstrations.

I certify that I have read or had this read to me the contents of this form and do realize the risks and limitations.

Signature: _____ **Date:** _____

(Patient, Parent, Guardian or Personal Representative)