Welcome to
Cheyenne Mountain Dental Center
"Your Healthy Mouth Connection"

1803 B Street
Colorado Springs, CO 80906
719-576-1730 or 877-433-9634 (toll free)

Thank you for choosing us for your dental needs. Please complete these forms. If you have any questions or concerns, do not hesitate to call us.

Who may we thank for referring you to us? _____

PATIENT INFORMATION

First Name _____ Last Name _____ Middle Initial ___

Patient is ☐ Policy Holder ☐ Responsible Party Preferred Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Ext _____ Cell Phone _____

Sex ☐ Male ☐ Female Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Employer _____

Date of Birth ___/___/___ Age ____ Soc Sec _____

E-Mail _____ Children? _____ Ages: _____

Emergency Contact _____

RESPONSIBLE PARTY (if different from above)

First Name _____ Last Name _____ Middle Initial ___

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Ext _____ Cell Phone _____

Date of Birth _____ Age _____ Soc Sec _____ Drivers Lic _____

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

PRIMARY INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc Sec _____ Insured Date of Birth _____

Employer _____ Insurance Company _____

SECONDARY INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc Sec _____ Insured Date of Birth _____

Employer _____ Insurance Company _____

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐ Yes ☐ No If yes, please explain _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain _____

Are you taking any medications, pills or drugs? ☐ Yes ☐ No If yes, please explain _____

Do you use tobacco? ☐ Yes ☐ No If yes, please explain _____

Do you use controlled substances? ☐ Yes ☐ No If yes, please explain _____

Women: are you ☐ Pregnant/Trying to get Pregnant? ☐ Nursing ☐ Taking Oral Contraceptives

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Local Anesthetics ☐ Foods

☐ Other If yes, please explain:

What Medications are you currently taking? _____

_____

_____

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

1. ☐ AIDS/HIV Positive	18. ☐ Cold Sores/Fever Blisters	35. ☐ Fainting Spells or Dizziness	52. ☐ Hives or Rash	69. ☐ Rheumatism
2. ☐ Alzheimer's Disease	19. ☐ Congenital Heart Disorder	36. ☐ Frequent Cough	53. ☐ Hypoglycemia	70. ☐ Scarlet Fever
3. ☐ Anaphylaxis	20. ☐ Contact Lenses	37. ☐ Frequent Diarrhea	54. ☐ Irregular Heartbeat	71. ☐ Shingles
4. ☐ Anemia	21. ☐ Constipation	38. ☐ Frequent Headaches	55. ☐ Kidney/Bladder Problems	72. ☐ Sickle Cell Disease
5. ☐ Angina	22. ☐ Convulsion	39. ☐ Frequent Urination	56. ☐ Leukemia	73. ☐ Sinus Trouble
6. ☐ Arthritis/Gout	23. ☐ Cortisone Medicine	40. ☐ Genital Herpes	57. ☐ Liver Disease	74. ☐ Skin Disease
7. ☐ Artificial Heart Valve	24. ☐ Diabetes	41. ☐ Glaucoma	58. ☐ Low Blood Pressure	75. ☐ Spina Bifida
8. ☐ Artificial Joint	25. ☐ Difficulty Swallowing	42. ☐ Hay fever	59. ☐ Lung Disease	76. ☐ Stomach/Intestinal Disease
9. ☐ Asthma	26. ☐ Difficulty Urinating	43. ☐ Heart Attach/Failure	60. ☐ Mitral Valve Prolapse	77. ☐ Stroke
10. ☐ Blood Disease	27. ☐ Drug Addiction	44. ☐ Heart Murmur	61. ☐ Pain in Jaw Joints	78. ☐ Swelling of Limbs/Joints
11. ☐ Blood Transfusion	28. ☐ Dry Mouth	45. ☐ Heart Pace Maker	62. ☐ Parathyroid Disease	79. ☐ Thyroid Disease
12. ☐ Blurred Vision	29. ☐ Easily Winded	46. ☐ Heart Trouble/Disease	63. ☐ Persistent Cough	80. ☐ Tonsillitis
13. ☐ Breathing Problems	30. ☐ Emphysema	47. ☐ Hemophilia	64. ☐ Psychiatric Care	81. ☐ Tuberculosis
14. ☐ Bruise Easily	31. ☐ Epilepsy or Seizures	48. ☐ Hepatitis A	65. ☐ Radiation Treatments	82. ☐ Tumors or Growths
15. ☐ Cancer	32. ☐ Excessive Bleeding	49. ☐ Hepatitis B or C	66. ☐ Recent Weight Loss	83. ☐ Ulcers
16. ☐ Chemotherapy	33. ☐ Excessive Thirst	50. ☐ Herpes	67. ☐ Renal Dialysis	84. ☐ Venereal Disease
17. ☐ Chest Pains	34. ☐ Eye Disease	51. ☐ High Blood Pressure	68. ☐ Rheumatic Fever	85. ☐ Yellow Jaundice

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform my dentist of any change in medical status.

_____ _____

Signature of Patient, Parent or Guardian Date

Medical History Review

_____

_____

_____

_____ _____

Doctors Signature Date

DENTAL HISTORY

Date of last dental visit _____ Last dental cleaning _____ Last full mouth X-rays _____

What was done at your last dental visit? _____

Previous Dentist's name _____

Address _____

City _____ State _____ Zip _____

Telephone Number _____

How often do you have dental examinations done? _____ How often do you brush your teeth? _____

How often do you floss? What other dental needs do you use? ☐tooth pick ☐electric brush ☐water pick ☐other

Do you have any dental problems/concerns now? ☐ Yes ☐ No

If yes, describe _____

Are you sensitive to	Check one	Comment
Hot, cold or sweets?	☐Yes ☐ No	
Biting or Chewing?	☐Yes ☐ No	
Have you noticed any mouth odors or bad taste?	☐Yes ☐ No	
Do you get cold sores, blisters or oral lesions?	☐Yes ☐ No	
Do your gums bleed or hurt?	☐Yes ☐ No	
Have your parents experienced gum disease or tooth loss?	☐Yes ☐ No	
Have you noticed any loose teeth or change in bite?	☐Yes ☐ No	
Does food tend to become caught in between your teeth? If yes, where?	☐Yes ☐ No	

Do you	Check one	Comment
Clench or grind your teeth while awake or asleep?	☐Yes ☐ No	
Bite your lips or cheeks regularly?	☐Yes ☐ No	
Hold foreign objects with your teeth? (Pencils, pipe, pins, nails, fingernails, etc)	☐Yes ☐ No	
Mouth breathe while awake or asleep?	☐Yes ☐ No	
Have tired jaws, especially in the morning?	☐Yes ☐ No	
Snore?	☐Yes ☐ No	
Stop breathing or gasp during sleep?	☐Yes ☐ No	

Have you ever had		
Orthodontic treatment? (Braces)	☐Yes ☐ No	
Oral Surgery?	☐Yes ☐ No	
Periodontal Treatment?	☐Yes ☐ No	
A bite plate or mouth guard?	☐Yes ☐ No	
Ground down teeth or bite adjustments	☐Yes ☐ No	
A serious injury to the mouth or head? If yes, please describe	☐Yes ☐ No	

DENTAL HISTORY continued

Have you experienced	Check one	Comment
Clicking or popping of the jaw?	☐Yes ☐ No	
Pain? (joint, ear, side of face)	☐Yes ☐ No	
Difficulty in opening/closing mouth?	☐Yes ☐ No	
Head, neck or shoulder aches?	☐Yes ☐ No	
Sore Muscles? (neck, shoulders)	☐Yes ☐ No	

Are you satisfied with your teeth's appearance?	☐Yes ☐ No	
Would you like to keep all of your teeth for the rest of your life?	☐Yes ☐ No	
Do you feel nervous about having dental treatment?	☐Yes ☐ No	
Have you ever had an upsetting dental experience? If yes, please describe	☐Yes ☐ No	
Is there anything else about having dental treatment that you would like us to know about?	☐Yes ☐ No	

I certify that I have provided the above information to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my children during the period of such dental care to third party payers and/or health practitioners. I hereby authorize the dentist of Cheyenne Mountain Dental Center and the staff working under their supervision to perform whatever dental procedures are necessary to accomplish the agreed upon treatment. I certify that I am the patient or duly authorized general agent of the patient to furnish the information requested. I acknowledge that payment is due at the time of services unless other financial arrangements have been made. I understand that treatment will be billed to my dental insurance company (if applicable) as a courtesy and authorize all dental insurance payments to be paid to Cheyenne Mountain Dental Center. I agree that parents and guardians are responsible for all fees and services rendered for the treatment of a minor child and I am responsible for payment of services.

Signature of Patient, Parent or Guardian _____ Date _____

Dental History Review:

_____

_____

_____

_____

_____

_____

Doctors Signature _____ Date _____