Signature Dental
Paul A. Dona, DDS
1201 S. Elk Street Casper, WY 82601
Phone: (307)234-3890 Fax: (307)472-5583
(Please Print)

## Patient Information:

Date:_____
SS #:_____
Patient Name:_____
Last Name
_____
First Name Middle Name

Address:_____
E-mail:_____
City:_____
State:_____ Zip:_____
Sex: ☐ M ☐ F Age:_____
DOB:_____
☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for _____ Years

Patient Employer/School:_____

Occupation:_____

Employer/School Address:_____
_____
Employer/School Phone: (___)_____

Spouse's Name: _____

DOB: _____ SS#:_____

Spouse's Employer:_____

Whom may we thank for referring you?_____

## Dental Insurance Information:

Who Is Responsible for this Account?_____
Relationship to Patient?_____
Insurance Co.:_____
Group #:_____ Sub. I.D. #:_____
Subscriber Name:_____
Is The Patient Covered by Additional Insurance?
☐ Yes ☐ No
Birthdate:_____ SS#:_____
Relation To Patient:_____
Secondary Insurance CO.:_____
Group #_____ Sub. I.D.:_____
Secondary Subscriber Name:_____

Assignment And Release:

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to (Name of Insurance company(ies)) Signature Dental/ Paul A. Dona, DDS all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for ALL CHARGES whether or not paid by my insurance company(ies). I authorize the use of my signature on all insurance submissions. Signature Dental/Paul A. Dona, DDS 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 ins. Benefits or the benefits payable for related services.

_____
Signature Of Patient, Parent, Guardian, Or Power Of Attorney

_____
Please Print Name Of Patient, Parent, Guardian, Or Power Of Attorney

_____ _____
Date: Relationship to Patient:

## Phone Numbers:

Home: (____)_____ Work: (____)_____EXT____ Other: (___)_____
Spouse's Work: (____)_____ Best Time To Contact You_____

IN CASE OF EMERGENCY: (Someone Who Does Not Live In Your Household)

Name:_____ Relationship:_____
Phone: (____)_____

## Dental History:

Reason For Today's Visit_____
_____
Former Dentist:_____
City/State:_____
Date Of Last Visit:_____
Date Of Last X-Rays: _____
Please mark Yes or No to indicate if you have had any of the following:

| | | |
|---|---|---|
| Bad Breath: | ☐ Yes | ☐ No |
| Bleeding Gums: | ☐ Yes | ☐ No |
| Blisters on Lips/Mouth: | ☐ Yes | ☐ No |
| Burning Sensation on Tongue: | ☐ Yes | ☐ No |
| Broken Fillings/Loose Teeth: | ☐ Yes | ☐ No |
| Cheek/Lip Biting: | ☐ Yes | ☐ No |
| Chew On One Side Of Mouth: | ☐ Yes | ☐ No |
| Dry Mouth: | ☐ Yes | ☐ No |
| Fingernail Biting: | ☐ Yes | ☐ No |
| Food collection Between Teeth: | ☐ Yes | ☐ No |
| Grinding Teeth: | ☐ Yes | ☐ No |
| Jaw Pain: | ☐ Yes | ☐ No |
| Mouth Breathing: | ☐ Yes | ☐ No |
| Mouth Pain, Brush/Floss: | ☐ Yes | ☐ No |
| Ortho Treatment: | ☐ Yes | ☐ No |
| Pain In Ear | ☐ Yes | ☐ No |
| Perio Treatment: | ☐ Yes | ☐ No |
| Popping/Clicking Jaw | ☐ Yes | ☐ No |
| Sensitivity to Cold: | ☐ Yes | ☐ No |
| Sensitivity to Heat: | ☐ Yes | ☐ No |
| Sensitivity When Biting: | ☐ Yes | ☐ No |
| Sensitivity to Sweets: | ☐ Yes | ☐ No |
| Smoking: | ☐ Yes | ☐ No |
| Sores in Mouth: | ☐ Yes | ☐ No |
| Swollen/Tender Gums: | ☐ Yes | ☐ No |

How Often do you Brush? _____
_____
How Often Do You Floss? _____
_____

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General Physician's Name: _____ Date Of Last Visit:_____

Have you ever used a bisphosphonate medication, such as Atelvia, Fosamax, Actonel, Didronel, or Boniva? ☐ Yes ☐ No

Have you ever taken any Fen-Phen Drugs such as Adipex, Fasin, Ionimin? ☐ Yes ☐ No

Please mark Yes or No to Indicate if you have any of the following:

| | | | | | |
|---|---|---|---|---|---|
| Abnormal Bleeding: | ☐Yes ☐No | Epilepsy: | ☐Yes ☐No | Respiratory Disease: | ☐ Yes ☐ No |
| AIDS/HIV: | ☐Yes ☐No | Dizziness/Fainting: | ☐Yes ☐No | Rheumatic Fever: | ☐ Yes ☐ No |
| Anemia: | ☐Yes ☐No | Glaucoma: | ☐Yes ☐No | Scarlet Fever: | ☐ Yes ☐ No |
| Arthritis: | ☐Yes ☐No | Heart Murmur: | ☐ Yes ☐No | Shortness Of Breath: | ☐ Yes ☐ No |
| Artificial Heart Valves: | ☐Yes ☐No | Heart Problems: | ☐ Yes ☐No | Sinus Trouble: | ☐ Yes ☐ No |
| Artificial Joints: | ☐Yes ☐No | Hepatitis Type:_____ | ☐Yes ☐No | Skin Rash: | ☐ Yes ☐ No |
| Asthma: | ☐Yes ☐No | Herpes: | ☐Yes ☐ No | Stroke: | ☐ Yes ☐ No |
| Back Problems: | ☐Yes ☐No | High Blood Pressure: | ☐Yes ☐ No | Swollen Feet: | ☐ Yes ☐ No |
| Blood Disease: | ☐Yes ☐No | Jaundice: | ☐Yes ☐No | Swollen Glands: | ☐ Yes ☐ No |
| Bloody or persistent cough: | ☐Yes ☐No | Jaw Pain: | ☐Yes ☐No | Thyroid Problems: | ☐ Yes ☐ No |
| Cancer: | ☐Yes ☐No | Kidney Disease | ☐Yes ☐No | Tuberculosis: | ☐ Yes ☐ No |
| Chemical Dependency: | ☐Yes ☐No | Liver Disease: | ☐Yes ☐No | Tumors: | ☐ Yes ☐ No |
| Chemotherapy: | ☐Yes ☐No | Low Blood Pressure: | ☐Yes ☐ No | Ulcers: | ☐ Yes ☐ No |
| Circulatory Problems: | ☐Yes ☐No | Migraines: | ☐Yes ☐No | Venereal Disease: | ☐ Yes ☐ No |
| Cortisone Treatments: | ☐Yes ☐No | Mitral Valve Prolapse: | ☐Yes ☐No | Unexplained Weight Loss: | ☐ Yes ☐ No |
| Diabetes: | ☐Yes ☐No | Nervous Problems: | ☐Yes ☐No | | |
| Emphysema: | ☐Yes ☐No | Pacemaker: | ☐Yes ☐No | | |
| Do you wear contact lenses? | ☐Yes ☐No | Psychiatric Care: | ☐Yes ☐No | | |

WOMEN:

Are you pregnant? ☐ Yes ☐ No Due Date:_____ Are you nursing? ☐ Yes ☐ No

Are you taking birth control pills? ☐ Yes ☐No

## Medications:

Please list any medications you are currently taking and the diagnosis for taking these medications:

_____
_____
_____
_____

Pharmacy Name:_____
Phone: (____)_____

## Allergies:

☐ Aspirin ☐ Codeine ☐ Iodine

☐ Latex ☐ Local Anesthetic ☐ Penicillin

☐ Sleeping Pills (Barbituates) ☐ Sulfa

☐Other

:_____
_____
_____

## Updates: To Be Filled Out At Future Appts.

- Has there been any change in your health since your last dental appt? ☐ Yes ☐ No
- If yes, what:_____
- Are you taking any new medications? ☐ Yes ☐ No
- If yes, what new medications are you taking and for what:_____
  _____

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- Has there been any change in your health since your last dental appt? ☐ Yes ☐ No
- If yes, what:_____
- Are you taking any new medications? ☐ Yes ☐ No
- If yes, what new medications are you taking and for what:_____
  _____