Plaza Dental

Dr. Daniel Van Buskirk
620 19th St West, Unit 200, Dickinson, ND 58601

We would like to get to know you better!

Date:_____

Patient Name: _____ SS#: _____-_____-_____ Male ☐ Female ☐

Patient's Date of Birth _____/_____/_____ Age: _____ Marital status (circle): Single/Married/Other

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

Occupation:_____ Employer: _____

Home Phone #: _____ Work Phone #: _____

Cell Phone #: _____ E-mail Address: _____

Spouse or Parent/Guardian: _____ SS# Spouse/Parent: _____-_____-_____

Address (if different than above): _____ Work #: _____

Spouse/Parent Occupation: _____ Employer: _____

Is anyone other than yourself responsible for your dental treatment? _____

Dental Insurance Information: If no insurance, please check here ☐ **Primary Insurance:** See copy of card: ☐

Name of Dental Carrier: _____ Subscriber #/Member ID _____

Address: _____ Subscriber Employer:_____

Subscriber Name: _____ Insurance Phone #: _____

Group #: _____ SS Number (subscriber): _____-_____-_____ Subscriber D.O.B. _____/_____/_____

Who may we thank for referring you? _____

Other family members that we treat? _____

When was your last dental appointment? _____ Where?_____

Why did you leave your last dental office?_____

What is your present dental need? _____

Are you concerned about the finances required to keep your mouth in excellent dental health? YES_____ NO _____

****

Are your teeth sensitive to:	**YES**	**NO**		**YES**	**NO**
Heat?	☐	☐	Pain (joints, ear, side of face)?	☐	☐
Cold?	☐	☐	Difficulty opening and closing?	☐	☐
Sweets?	☐	☐	Difficulty chewing?	☐	☐
Biting Pressure?	☐	☐	Have you had a reaction to local anesthetic?	☐	☐
Are you dissatisfied with your teeth and their appearance?	☐	☐	Do your gums bleed when brushing?	☐	☐
Have you noticed any gum swelling around any teeth?	☐	☐	Have you ever had any teeth removed?	☐	☐
Do you have an unpleasant taste or odor in your mouth?	☐	☐	How long have these been missing? _____		
Do you feel you will eventually wear artificial dentures?	☐	☐	**Problems of the Jaw?**		Do
Do you have any fears?	☐	☐	Clicking of the jaw?	☐	☐

Patient Name: _____ D.O.B: _____ Date: _____

IN CASE OF AN EMERGENCY, PERSON TO BE CONTACTED:

Name: _____ Phone #: _____

Relationship: _____ Address: _____

HEALTH INFORMATION:

Primary Care Physician: _____ Which Clinic/Hospital?: _____

Y N

□ □ Have you been hospitalized within the past 2 years? If yes, for what? _____

□ □ Are you currently being treated by a physician? If yes, for what? _____

_____

□ □ Are you currently taking any medications or drugs? If yes, please list:_____

_____

□ □ Are there any medical issues that we should know about? _____

_____

□ □ Do you use any Tobacco products? If yes, what? _____

□ □ Have you ever had an addiction problem with alcohol, drugs, or prescription medications? Explain:_____

_____

FEMALE Yes No	**Are you nursing:** ☐ Yes ☐ No
Are you pregnant: ☐ ☐	**Are you taking any form of birth control?** ☐ Yes ☐ No
If yes, when are you due? _____	**If yes, I understand if given medication this may affect the**
How many weeks? _____	**Effectiveness of birth control. INITIAL** _____

Y N Conditions	Y N Conditions	Y N Conditions
☐ ☐ High Blood Pressure	☐ ☐ Asthma	☐ ☐ Acid Reflux
☐ ☐ Low Blood Pressure	☐ ☐ Emphysema	☐ ☐ Thyroid Problems
☐ ☐ High Cholesterol	☐ ☐ Abnormal/Difficulty Breathing	☐ ☐ Psychiatric Problems
☐ ☐ Heart surgery	☐ ☐ Sinus Problems	☐ ☐ Hearing Impaired
When? _____	☐ ☐ Tuberculosis	☐ ☐ Fainting Spells
☐ ☐ Heart Attack	☐ ☐ Osteoporosis/Osteopenia	☐ ☐ Frequent Headaches
When? _____	☐ ☐ Bisphosphonate use	☐ ☐ Epilepsy
☐ ☐ Stroke	examples: Boniva, Actonel, Zometa	☐ ☐ Seizures
When? _____	☐ ☐ Arthritis/Rheumatoid Arthritis	☐ ☐ Organ Transplant
☐ ☐ Pace Maker	☐ ☐ Artificial Bones/Joints	Y N Allergies
☐ ☐ Angina Pectoris	Dates? _____	☐ ☐ Seasonal
☐ ☐ Congenital Heart Defect	☐ ☐ Diabetes: Type I or II	☐ ☐ Aspirin
☐ ☐ Rheumatic Fever	☐ ☐ Hemophilia	☐ ☐ Codeine
☐ ☐ Mitral Valve Prolapse	☐ ☐ Anemia	☐ ☐ Dental Anesthetics
☐ ☐ Heart Murmur	☐ ☐ Abnormal Bleeding	☐ ☐ Erythromycin
☐ ☐ Artificial Heart Valve	☐ ☐ HIV + AIDS	☐ ☐ Latex
☐ ☐ Cancer	☐ ☐ Liver Disease	☐ ☐ Metals
☐ ☐ Chemotherapy	☐ ☐ Hepatitis A	☐ ☐ Sulfa
When? _____	☐ ☐ Hepatitis B	☐ ☐ Penicillin/Amoxicillin
☐ ☐ Radiation	☐ ☐ Hepatitis C	☐ ☐ Tetracycline
When? _____		Other: _____
		_____

I grant that any information regarding dental/medical care provided by Plaza Dental may be received by the following people:

Name: **Relationship**

_____

_____

Signature of Patient or Guardian: _____ **Date:** _____

(Must be signed)