James D. Spivey, D.D.S., M.S.
278 Lafayette Road Bldg. E
Portsmouth, NH 03801

WELCOME

Thank you for selecting our dental healthcare team!
We strive to provide you with the best possible dental care.
Please fill out this form completely in ink.

Patient Information

Today's Date / /20

First Name	Middle	Last Name		
Home Address		City/town	State	Zip
Mailing Address (if different)		City/town	State	Zip
E-mail		General Dentist		
❑ Home Phone	❑ Work Phone	❑ Cell Phone		
PLEASE CHECK ABOVE THE PREFERRED DAYTIME PHONE NUMBER THAT YOU CAN BE REACHED.				
Date of Birth	Age	Sex ❑ M ❑ F	SS#	
Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed				
Employer		Occupation		
Person to Contact in Case of Emergency		Relationship to Patient		
Whom May We Thank for Referring You to Us?				
Name of Person Responsible for This Account		Phone Number		
Home Address	City/town	State	Zip	
Relationship to Patient	Employer	SS#	Date of Birth	

Dental Insurance

PRIMARY Insurance Company Name	Employee ID#	Group Name	Group #
Insurance Co. Address	City		State/Zip
Insurance Co. Phone Number			
Name of Insured	Relationship to Patient		
Insured's Date of Birth	SS#		
SECONDARY Insurance Company Name	Employee ID#	Group Name	Group #
Insurance Co. Address	City		State/Zip
Insurance Co. Phone Number			
Name of Insured	Relationship to Patient		
Insured's Date of Birth	SS#		

Medical History

Name of Primary Care Physician_____ Phone: ( ) _____

Are you currently under the care of a physician? ❑Yes ❑No

Is your current physical health? ❑Good ❑Fair ❑Poor

Date of last Physical Exam: _____

Do you smoke or use tobacco in any form? ❑Yes ❑No

Have you had a blood transfusion? ❑Yes ❑No

Have you ever been seriously ill or hospitalized? ❑Yes ❑No For what? _____

Do you drink more than one alcoholic beverage per day? ❑Yes ❑No

Are you taking any of the following drugs (please check the appropriate boxes)

❑ Antibiotics ❑Aspirin ❑ Vitamins
❑Cortisone ❑Heart Medicine ❑ Hormones
❑Tranquilizers ❑Sleeping Pills ❑ Insulin
❑Anticoagulants (Blood Thinners) ❑Blood Pressure Medicine

Have you ever had any of the following infectious diseases? (please check the appropriate boxes)

❑Hepatitis ❑Tuberculosis ❑Herpes
❑HIV/ AIDS ❑Venereal Disease
❑Other _____

Does Your Physician Recommend Antibiotics for Dental Cleanings?

❑ Yes ❑ No

Have you had abnormal bleeding associated with any of the following:

❑Extractions ❑Surgery ❑Menstruation

Do you have or ever had?

❑ Heart Murmur ❑ Hip or Joint Replacement
❑ Organ Transplant ❑ Prolapsed Mitral Valve

Is there a family history of the following illnesses?

❑ Diabetes ❑ Heart Problems ❑ Cancer
❑ Other _____

Please list any other serious medical condition(s) that you have or had. _____
_____

Do you have or have you ever had any of the following?
(please check the appropriate boxes)

❑Alcohol Abuse	❑Chest Pain/Exertion	❑Glaucoma	❑Liver Disorder	❑Shortness of Breath
❑ Anemia	❑Chronic fatigue	❑Hay Fever	❑Low Blood Pressure	❑Sickle Cell Disease
❑ Anorexia	❑Colitis	❑Headaches	❑Lung Problems	❑Sleep Apnea
❑ Arthritis	❑Congenital Heart Lesion	❑Heart Attack	❑Lupus	❑Steroid Therapy
❑ Artificial Valves	❑Depression	❑Heart Palpitations	❑Pacemaker	❑Stroke
❑ Asthma	❑Diabetes	❑Heart Surgery	❑Persistent Cough	❑Tension
❑ Blood Transfusion	❑Epilepsy	❑Hemophilia	❑Radiation Treatment	❑Thyroid Problems
❑ Bulimia	❑Fainting/Dizziness	❑High Blood Pressure	❑Rheumatic Fever	❑Tumors
❑Cancer	❑Fever blisters	❑Jaundice	❑Scarlet Fever	❑Ulcers
❑Chemotherapy		❑Kidney Disorder	❑Chicken Pox/ Shingles	

Medical History Continued

For Women:	*Are You Taking Birth Control Medication?*	❑ Yes	❑ No	
	Are you pregnant?	❑ Yes	❑ No	❑Unsure
	Do you have Osteoporosis?	❑ Yes	❑ No	
	Menopause /Post-Menopause	❑ Yes	❑ No	❑Unsure

Are you allergic to any of the following? (check all that apply)

❑ Aspirin	❑ Advil	❑ Aleve	❑ Barbiturates/Sedatives	❑ Codeine
❑ Demerol	❑ Dental Anesthetics	❑ Erythromycin	❑ Latex	❑ Ibuprofen
❑ Penicillin	❑ Sulfa drugs	❑ Tetracycline	❑ Tylenol	❑ Valium

❑Other _____

Do you have any other allergic conditions like? (check all that apply)

❑ Asthma ❑ Skin Rashes or Hives ❑ Hay Fever ❑ Sinus Problems ❑Other_____

Dental History

What dental concerns do you have today?

Are your teeth sensitive to? ❑Cold ❑Heat ❑Biting Pressure ❑Brushing ❑ Sweet

Has your dental care been:
❑ Regular ❑ Intermittent ❑ Infrequent

Approximate Date of Last Dental Visit? _____
❑ Check-up ❑ Treatment ❑ Cleaning

How many cleanings have you had in the last 5 years?

Has a dentist or hygienist shown you how to clean your teeth? ❑ Yes ❑ No

Have you ever had periodontal care? ❑ Yes ❑ No
If yes, when? _____

Have you ever had braces? ❑ Yes ❑ No
If yes, when? _____

Please check the items below that you use to take care of your teeth.

❑ Hand Tooth Brush
❑ Electric Tooth Brush
❑ Dental Floss
❑ Tooth Picks
❑ Stimudents
❑ Rubber Tips
❑ Water Pik
❑ Other _____

Have you ever experienced the following?

❑ Bad Breath/Taste
❑ Swelling Gums
❑Bleeding Gums
❑ Loose Teeth
❑ Pus Around Teeth
❑ Drifting Teeth
❑ Broken Filling(s)
❑ Receding Gums
❑ Spaces Between Teeth
❑ Foul Odor from Teeth/Gums
❑ Food Packing Between Teeth

Are you satisfied with the appearance of your teeth?	❑Yes	❑No
Do you clench or grind your teeth?	❑Yes	❑No
Have you ever suffered from face/ mouth/ neck/ jaw pain?	❑Yes	❑No
Are you presently having mouth/ face/ jaw pain?	❑Yes	❑No
Did/Do your parents have false teeth?	❑Yes	❑No
Have you ever had an injury to your face, mouth, or jaw(s)?	❑Yes	❑No
Is it important for you to keep your teeth?	❑Yes	❑No

Notice of Privacy Practices (HIPPA)

- ❑ ***I Acknowledge that I have received the Notice of Privacy Practices***
- ❑ ***I have been offered but declined to receive the Notice of Privacy Practices.***

I give permission for your office to discuss my treatment & account with:

1)_____

2)_____
Name(s)

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize Dr. Spivey's office to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such periodontal/dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to Dr. Spivey's office. ***I understand that my dental insurance carrier may pay less than the actual bill for services****. I agree to be responsible for payment of* ***all services*** *rendered on my behalf.*

X _____
Signature of Patient/Parent/Guardian Date