Franklin Dentistry Associates

Dr. Trent Rehnquist, D.D.S.

"Changing Lives, One Smile at a Time"

Patient Information

Date _____

Name_____ Occupation_____

Name of Guardian_____ Employer_____

SSN/ID _____ Employer Address_____

Address_____ If in school, where _____

City _____ _____

State _____Zip_____ Spouse's Name_____

Phone _____ Spouse's DOB_____

Work _____Cell_____ SSN/ID_____

Email_____ Spouse's Employer _____

Sex __M __F Age____ DOB _____ Whom may we thank for referring you?

__Married __Widowed __Single _____

__Separated __Divorced __Minor

What would be the best way to contact you regarding appointments or questions? (Check all that apply)

Home ____ Work ____ Cell ____ Email ____ Text ____

In case of emergency, Contact (someone who does not live in your household)

Name_____ Relationship_____

Phone_____Cell_____Work_____

Preferred Pharmacy _____City_____ _____Phone #_____

Reason for today's visit _____

Former Dentist _____ City/State_____

Date of last dental visit _____ Date last X-rays_____

How often do you floss_____ How often do you brush_____

Dental Insurance

Primary Insurance

Subscriber name _____

Relationship_____

DOB_____ SSN_____

Ins. Co._____

Group#_____

Phone_____

Secondary Insurance

Subscriber name_____

Relationship_____

DOB_____SSN_____

Ins. Co._____

Group#_____

Phone_____

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.

Insurance Assignment: I certify that I, and/or my dependent(s), have insurance coverage with_____ and assign directly **Dr. Trent Rehnquist** 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 insurance. I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care 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. The consent will end when my current treatment plan is completed or one year from the date signed.

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative Date

_____ _____

Please print the name of Patient, Parent, Guardian, or Personal Representative Date

Are you allergic to:

	Yes	No		Yes	No
Aspirin	___	___	Barbiturates	___	___
Codeine	___	___	Ibuprofen	___	___
Latex	___	___	Local Anesthesia	___	___
Metals (i.e. gold)	___	___	Penicillin	___	___
Sulfa/Tetracycline	___	___	Other _____		

Please PRINT all medications now taking:_____

Medical History

Please check if "yes" or "no" to indicate if you have had any of the following:

	Yes	No		Yes	No
Aids	___	___	Kidney disease	___	___
Anemia type_____	___	___	Liver disease	___	___
Arthritis, Rheumatism	___	___	Low blood pressure	___	___
Asthma	___	___	Nervous problems	___	___
Back problems	___	___	Psychiatric care	___	___
Cancer type _____	___	___	Radiation treatment	___	___
Chemical dependency	___	___	Respiratory disease	___	___
Chemo date_____	___	___	Scarlet fever	___	___
Circulatory problems	___	___	Seizures	___	___
Cortisone treatments	___	___	Shortness of breath	___	___
Cough, persistent or bloody	___	___	Sinus trouble	___	___
Diabetes type_____	___	___	Skin rash	___	___
Emphysema	___	___	Special diet/weight loss	___	___
Epilepsy	___	___	Stroke date_____	___	___
Fainting or dizziness	___	___	Swollen feet or ankles	___	___
Glaucoma	___	___	Swollen neck glands	___	___
Headaches	___	___	Thyroid problems	___	___
Heart problems	___	___	Tobacco User	___	___
Hepatitis type _____	___	___	Tuberculosis date _____	___	___
Herpes	___	___	Tumors or growths where?	___	___
High blood pressure	___	___	Ulcer	___	___
HIV positive	___	___	Venereal disease	___	___
Jaundice	___	___	type _____		

Have you ever taken any of these medications?

Have you ever had or been diagnosed with:

	Yes	No		Yes	No
Blood thinners	___	___	Artificial heart valves	___	___
Coumadin	___	___	Artificial joints	___	___
Warfarin	___	___	Artificial pins, screws, etc	___	___
Diet Medications	___	___	Bleeding abnormally, with		
Dexfenfluramine	___	___	extractions or surgery	___	___
Fen-phen	___	___	Blood disease	___	___
Pondimin	___	___	Congenital heart disease	___	___
Redux	___	___	Heart Endocarditis	___	___
Fosonimides	___	___	Hernia repair	___	___
Levoxyl	___	___	Pacemaker	___	___
Synthroid	___	___	Rheumatic fever	___	___

Dental History

	Yes	No		Yes	No
Bad breath	___	___	Jaw pain or tiredness	___	___
Bleeding gums	___	___	Lip or cheek biting	___	___
Blisters on lips/mouth	___	___	Loose teeth/broken fillings	___	___
Burning sensation	___	___	Mouth breathing	___	___
Chew on one side	___	___	Mouth pain	___	___
Cigarette/pipe/cigar	___	___	Orthodontic treatment	___	___
Clicking or popping jaw	___	___	Pain around ear	___	___
Dry mouth	___	___	Periodontal treatment	___	___explain _____
Fingernail biting	___	___	Sensitivity to cold	___	___
Food collection in teeth	___	___	Sensitivity to hot	___	___
Foreign objects mouth	___	___	Sensitivity to sweets	___	___
Grinding teeth	___	___	Sensitivity to biting	___	___
Gums swollen or tender	___	___	Sores or growths in mouth	___	___

Are you pregnant _____ Taking birth control pills _____

Due date _____ Are you nursing _____

Patient Signature_____ Date _____