Dr. Sean Sherry DDS, AFAAID, FAGD
Dr. Phillippe Freeman DMD, MAGD

Patients Name: ______________________ Nickname: ______________________
Date of Birth: ______________________ Today's Date: ______________________
SS#: ______________________ Email: ______________________
Preferred Phone: ______________________ Second Phone: ______________________
Who can we thank for referring you to Our Office? ______________________
Home Address: ______________________ Zip/State: ______________________
Occupation: ______________________ Employer: ______________________
Person Responsible for Account: ______________________ Marital Status: ______________________
Spouse's Name: ______________________ Date of Birth: ______________________ Spouse SS#: ______________________
Spouse's Occupation: ______________________ Employer: ______________________
Emergency Contact name and phone number: ______________________

Please provide a copy of your insurance card(s) or fill out section below.

PRIMARY INSURANCE

Insurance Co: ______________________
ID #: ______________________
Group #: ______________________
Ins. Co. Address: ______________________
____
Phone #: ______________________
Name of insured: ______________________
Relationship to patient: ______________________
DOB of insured: ______________________
Employer: ______________________

SECONDARY INSURANCE

Insurance Co: ______________________
ID #: ______________________
Group #: ______________________
Ins. Co. Address: ______________________
____
Phone #: ______________________
Name of insured: ______________________
Relationship to patient: ______________________
DOB of insured: ______________________
Employer: ______________________

After initial radiographs and examination, we will provide you with an estimate of fees to cover treatment. All estimates are based upon conditions as viewed at the time of diagnosis; unforeseen circumstances could alter an estimated fee. As all dental insurance policies vary in benefits, you can estimate that your policy probably covers between 40%-80% of your routine dental treatment. As a courtesy to you we will submit the forms for your benefits. Payment of the remaining balance is your responsibility

*** Crowns, bridges and removable prosthesis restorations require a minimum payment of 50% by the first appointment if patient has insurance coverage.**
*** Cosmetic services such as teeth whitening, veneers, smile makeovers, implants or other elective cosmetic enhancements, require payment in full at time of treatment, if not otherwise covered by insurance benefits.**
***Any services not estimated to be covered by insurance will be collect at time of service.**

Authorization for release of health information: *I authorize the health care provider to release to my insurance company any Information including x-rays that may be needed to evaluate a claim for benefits.*

159 SW Shevlin Hixon Drive, Bend OR 97702 PH (541)317-1300 FAX (541)317-1351 info@deschutesdentalcenter.com

DESCHUTES
DENTAL CENTER

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MEDICAL HISTORY

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD: YES NO

1. Hospitalization for illness or injury ________ ☐ ☐
2. An allergic or bad reaction to any of the following: aspirin, ibuprofen, acetaminophen, ☐ ☐
   - O codeine ________
   - O penicillin ________
   - O erythromycin ________
   - O tetracycline ________
   - O sulfa ________
   - O local anesthetic ________
   - O fluoride ________
   - O chlorhexidine (CHX) ________
   - O Iodine ________
   - O metals (nickel, gold, silver, ________)
   - O latex ________
   - O nuts ________
   - O fruit ________
   - O milk ________
   - O red dye ________
   - other ________
3. Heart problems, or cardiac stent within the last six month ☐ ☐
4. History of infective endocarditis________ ☐ ☐
5. Artificial heart valve, repaired heart defect (PFO) ________ ☐ ☐
6. Pacemaker or implantable defibrillator ________ ☐ ☐
7. Artificial Joint replacement________ ☐ ☐
8. Heart murmur, rheumatic or scarlet fever ________ ☐ ☐
9. High or low blood pressure ________ ☐ ☐
10. A stroke (taking blood thinners) ________ ☐ ☐
11. Anemia or other blood disorder ________ ☐ ☐
12. Prolonged bleeding due to a slight cut (or INR > 3.5) ________ ☐ ☐
13. Pneumonia, emphysema, shortness of breath, sarcoidosis ________ ☐ ☐
14. Chronic ear infections, tuberculosis, measles, chicken pox ☐ ☐
15. Breathing problems (e.g. asthma, stuffy nose, sinus congestion) ________ ☐ ☐
16. Sleep problems (e.g. sleep apnea, snoring, insomnia, restless sleep, bedwetting) ________ ☐ ☐
17. Kidney disease ________ ☐ ☐
18. Liver disease or jaundice ________ ☐ ☐
19. Vertigo (e.g. "the room is spinning") ________ ☐ ☐
20. Thyroid, parathyroid disease, or calcium deficiency ________ ☐ ☐
21. Hormone deficiency or imbalance (e.g. poly cystic ovarian syndrome) ________ ☐ ☐
22. High cholesterol or taking statin drugs ________ ☐ ☐
23. Diabetes (HbA1c = ________) ________ ☐ ☐
24. Stomach or duodenal ulcer ________ ☐ ☐
25. Digestive or eating disorders (e.g. celiac disease, gastric reflux, bulimia, anorexia) ________ ☐ ☐

YES NO

26. Osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g. bisphosphonates) ________ ☐ ☐
27. Arthritis or gout ________ ☐ ☐
28. Autoimmune disease (e.g. rheumatoid arthritis, lupus, scleroderma) ________ ☐ ☐
29. Glaucoma ________ ☐ ☐
30. Contact lenses ________ ☐ ☐
31. Head or neck injuries ________ ☐ ☐
32. Epilepsy, convulsions (seizures) ________ ☐ ☐
33. Neurologic disorders (e.g. Alzheimer's disease, dementia, prion disease) ________ ☐ ☐
34. Viral infections and cold sores ________ ☐ ☐
35. Any lumps or swelling in the mouth ________ ☐ ☐
36. Hives, skin rash, hay fever ________ ☐ ☐
37. STI/STD/HPV ________ ☐ ☐
38. Hepatitis (type _) ________ ☐ ☐
39. HIV/AIDS ________ ☐ ☐
40. Tumor, abnormal growth ________ ☐ ☐
41. Radiation therapy ________ ☐ ☐
42. Chemotherapy, immunosuppressive medication ________ ☐ ☐
43. Emotional difficulties ________ ☐ ☐
44. Psychiatric treatment or antidepressant medication ☐ ☐
45. Concentration problems or ADD/ADHD ________ ☐ ☐
46. Alcohol/recreational drug use ________ ☐ ☐

ARE YOU:

47. Presently being treated for any other illness ☐ ☐
48. Aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea) ________ ☐ ☐
49. Taking medication for weight management________ ☐ ☐
50. Taking dietary supplements, vitamins, &/or probiotics ☐ ☐
51. Often exhausted or fatigued ________ ☐ ☐
52. Experiencing frequent headaches or chronic pain ________ ☐ ☐
53. A smoker, smoked previously or other (e.g. smokeless tobacco, vaping, e-cigarettes, and cannabis) ________ ☐ ☐
54. Considered a touchy/sensitive person ________ ☐ ☐
55. Often unhappy or depressed ________ ☐ ☐
56. Taking birth control pills ________ ☐ ☐
57. Currently pregnant ________ ☐ ☐
58. Diagnosed with a prostate disorder ☐ ☐

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Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

____

____

****Please list all medications, supplements, vitamins, and/or probiotics taken within the last two years below. ***

Please be sure to include all prescription drugs, over the counter drugs, vitamins, and herbal supplements

MEDICATION	DOSAGE	HOW MUCH AND WHEN	REASON FOR USE

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature (parent or guardian):________________________Date:____________

Doctor's Signature:________________________________Date:____________

ASA ____ (1-6)

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