RAYBURN DENTAL
GENERAL DENTISTRY

Dr. Sherry Rayburn, DMD

Patient Information (*Confidential*)

Name _____ Birth date _____

Address _____ City _____ Prov _____ Postal Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

E-mail _____

Emergency Contact _____ phone # _____

Whom Shall We Thank For Your Referral _____

Family/Friend Website Newspaper Yellow Pages Sign Radio *Other*

Primary Insurance Policy

Insurance Company _____ Policy # _____ Sub ID # _____

Policy Holders Name _____ Policy holders Date of Birth _____

Place of Employment _____ Work Phone _____

Secondary Insurance Policy

Insurance Company _____ Policy # _____ Sub ID # _____

Policy Holders Name _____ Policy holders Date of Birth _____

Place of Employment _____ Work Phone _____

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

	Yes	No
1. Do your gums bleed while you brush?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Do you feel pain in any of your teeth?	☐	☐
4. Do you have any sores/lumps in your mouth?	☐	☐
5. Have you had any head, neck, jaw injuries?	☐	☐
6. Have you ever experienced any clicking or pain in the TMJ area, difficulty opening or closing of your jaw?	☐	☐
7. Do you have frequent headaches?	☐	☐
8. Do you clench or grind your teeth?	☐	☐
9. Do you bite your lips or cheeks frequently?	☐	☐
10. Have you ever had any difficult extractions or prolonged bleeding from it in the past?	☐	☐
11. Have you had any orthodontic treatment?	☐	☐
12. Do you wear dentures or partial?	☐	☐

Do you have any concerns about your dental aesthetics?

_____

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Patient Medical History

Family Physicians Name_____

1. Are you currently under any medical treatment? If yes, please explain

_____

2. Have you been admitted to a hospital or needed emergency care during the past two years? If yes, please explain

_____

3. Are you currently taking any medications, including over the counter medications? Please list all

_____

4. Have you ever had any complications following dental treatment? If yes please explain

_____

5. Do you or have you had heart trouble or stroke? Yes ☐ No ☐

6. Allergies: Have you ever had a reaction to any of the following:

☐	Local Anesthetic (freezing)	☐	Aspirin
☐	General Anesthetic	☐	Latex
☐	Codeine	☐	Penicillin
☐	other: _____		

7. Are you nervous? Yes ☐ No ☐

8. Are you pregnant? Yes ☐ No ☐
if yes please list due date:_____

9. Do you have or have had any of the following? Please check all that apply.

AIDS/HIV ☐	Head Injuries ☐	Respiratory Problems ☐
Anemia ☐	Heart Disease ☐	Stomach Problems ☐
Arthritis ☐	Heart Murmur ☐	Sinus Problems ☐
Artificial Joints ☐	Hepatitis ☐	Tuberculosis ☐
Asthma ☐	High Blood Pressure ☐	Tumors ☐
Blood Disease ☐	Kidney Disease ☐	Venereal Disease ☐
Cancer ☐	Liver Disease ☐	Diabetes ☐
Dizziness ☐	Mental Disorders ☐	Smoker ☐
Epilepsy ☐	Pacemaker ☐	Other:_____
Excessive Bleeding ☐	Radiation Therapy ☐	
Fainting ☐	Rheumatic Fever ☐	
Glaucoma ☐	Rheumatism ☐	

Consent for Services

I agree to pay value of said services which shall be as billed, unless objected to by me, in writing, within the time for payment thereof. I agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I understand my personal information disclosed is protected by the Privacy Act. I agree that Rayburn Dental can electronically file dental claims on my behalf.

I have read the above conditions of treatment and payment and agree to their content.

_____ _____

Signature of patient, parent or guardian ***Date***