Cole Dental
STEPHANIE J. MOWER, DMD MICHAEL A. MOWER, DDS

1166 No. Cole Rd.
Suite A
Boise, Idaho 83704
(208)377-8383

Patient Information

Date _____

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Birthdate _____ Social Security # _____

If patient is a minor, give parent's or guardian's name _____

Whom may we thank for referring you to our office? _____

Responsible Party Information

Name _____
Last First Middle Marital Status

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 yrs.) _____
Street City State Zip

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____
Last First Middle

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Insurance Information

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Do you have dual coverage? Yes ☐ No ☐ If yes:

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Insured's Employer _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____

I understand that where appropriate, credit bureau reports may be obtained.

CONFIDENTIAL (for record and pretreatment evaluation)

DENTAL HISTORY

1. What prompted you to seek dental care at this time? _____
2. How long since your last thorough dental examination? _____
3. Have you experienced any discomfort from your teeth or gums lately? If so where? _____
4. Have you ever been told you have gum disease? _____
5. Has the fear of discomfort kept you from regular dental visits? _____
6. Do your gums bleed easily, fell tender, or irritated? _____
7. Are you aware of grinding or clenching, pain in TMJ (jaw)? _____
8. Does local anesthetic work well for you? _____
9. Do you want to improve the appearance of your smile? _____
10. May we request your dental records from your previous dentist? _____ If yes, please give Dr.'s name, address & phone. _____

MEDICAL HISTORY

1. Have you been a patient in the hospital during the past two years? _____
2. Have you been under the care of a medical doctor during the past two years? _____
3. Name of physician. _____
4. Have you taken any medicine or drugs during the past two years? _____ If yes, please list: _____

   _____
5. Are you allergic or sensitive to: penicillin, aspirin, codeine, novocaine, or any drugs or medications? _____ If yes, please list: _____
6. Women: Are you pregnant now? _____ Do you anticipate becoming pregnant? _____
7. Please circle any of the following which you had or have at present:

☐ Heart Trouble	☐ Cancer, Tumor	☐ AIDS
☐ High/Low Blood Pressure	☐ Tuberculosis (TB)	☐ Hepatitis
☐ Rheumatic Fever	☐ Asthma, Hay Fever, Sinus Trouble	☐ Psychiatric Treatment
☐ Heart Murmur	☐ Emphysema	☐ Drug Addiction
☐ Artificial Heart Value	☐ Diabetes	☐ Venereal Disease
☐ Replacement Joints	☐ Thyroid Disease	☐ Blood Transfusion, Bleeding
☐ Stroke	☐ X-Ray Treatment, Chemotherapy	☐ Hemophilia
☐ Kidney Trouble	☐ Arthritis	
☐ Ulcers	☐ Cortisone Medicine	

8. Do you have any disease, condition, or problem not listed? _____

_____

To the best of my knowledge, all the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor of dentistry at the next appointment without fail.

_____

Date Staff Signature Signature of Patient, Guardian, or Parent

MEDICAL HISTORY/PHYSICAL EVALUATION UPDATE

Date	Addition	Signature of Patient, Parent, or Guardian	Staff Int.

STEPHANIE J. MOWER, DMD MICHAEL A. MOWER, DDS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____