Loveland Dental Hygiene, LLC
Tina Riss, RDH

Patient Information

Patient's Last Name	First Name	Middle	Preferred	Gender
Date of Birth	Preferred Phone Number	Other Phone	Email Address	
Home Address	Apt or Box No.	City	State	Zip Code
Emergency Contact – Name Relation Daytime Phone No. Address (Street, City, State, Zip)				

Parent/Guardian Information

Last Name	First Name	Middle	Preferred	Gender
Date of Birth	Preferred Phone Number	Other Phone	Email Address	
Home Address	Apt or Box No.	City	State	Zip Code

Patient's Primary Dental Insurance Information

Subscriber's Name	Subscriber's ID	Subscriber's DOB	Insurance Co.	Group No.
Employer	Address of Employer		Subscriber's Relationship to Patient	

Consent for Services

____ I understand that I am being seen by a licensed Colorado Dental Hygienist. I have been informed that the ADA recommends a dentist exam every 6 months.

____I understand that Loveland Dental Hygiene will have my radiographs viewed and evaluated by a licensed dentist.

____I understand that communication will be done via email and that it may not be encrypted. (appointment reminders, x-rays, treatment notes, etc.)
Things like social security number and account information will not be shared, unless with an insurance company, which is encrypted.

___ Payment is solely the responsibility of the patient or responsible party. We will gladly bill insurance as a service to you, but any nonpayment or partial payment is then the patient's responsibility. Nonpayment may result in turning over your account to a collections agency.

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

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

Health and Dental History

Date of last physician (medical Dr.) Visit_____MD Name:_____Phone:_____

Have you ever had any of the following? Please check those that apply:

☐ AIDS	☐ Cold Sores	☐ Head Injury	☐ Kidney Disease	☐ Rheumatic Fever
☐ Allergies	☐ Diabetes	☐ Heart Disease	☐ Liver Disease	☐ Sinus Problems
☐ Asthma	☐ Dizziness	☐ Heart Murmur	☐ Mental Disorders	☐ Stomach Problems
☐ Anemia	☐ Epilepsy/seizures	☐ Heart Valve Replaced	☐ Nervous Disorders	☐ Stroke
☐ Arthritis	☐ Excessive Bleeding	☐ Hepatitis –Type A, B, C	☐ Pacemaker/Defibrillator	☐ Thyroid Problems
☐ Artificial Joints	☐ Fainting	☐ High Blood Pressure	☐ Pregnancy—Due Date:	☐ Tuberculosis
☐ Blood Disease	☐ Glaucoma	☐ Irregular heart rhythm	☐ Radiation Treatment	☐ Tumors
☐ Cancer	☐ Hay Fever	☐ Jaundice	☐ Respiratory Problems	☐ Ulcers

- **Have you ever had any complications following dental treatment? ☐ Yes ☐ No**
  If yes please explain:_____
- **Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No**
  If yes please explain:_____
- **Are you now under the care of a physician? ☐ Yes ☐ No**
  If yes please explain:_____
- **Do you have any health problems that require further explanation? ☐ Yes ☐ No**
  If yes please explain:_____

Are you allergic to any of the following? Check all that apply:

☐ Codeine	☐ Erythromycin	☐ Foods/food Dyes	☐ Latex
☐ Local Anesthetics	☐ Metals	☐ Penicillin	☐ Other

Please List all Medications & Supplements(or attach a copy)

Dental History

Name of Dentist (current or former)_____ **Date of Last Visit**_____
Reason for Today's visit_____ **Current Home Care (circle) Brush Floss Water Pik Other**
Do you like your smile?_____ **Have you ever used or are you interested in whitening?**_____
Please Circle:

Do your gums bleed? Yes No	**Do you have any pain In your mouth or teeth? Yes No**
Do you have any lumps or sores in your mouth? Yes No	**Do you have jaw pain? Yes No**
Are your teeth sensitive to hot or cold? Yes No	**Are your teeth sensitive to sweet? Yes No**
Do you grind or clench your teeth? Yes No	**Do you wear a night guard or retainer? Yes No**
Do you have frequent headaches? Yes No	**Do you have any dental implants? Yes No**

Any other Dental Concerns:_____