Jeremy J. Larson, DMD LLC
1090 W Hermiston Ave.
Hermiston, OR 97838
(541) 567-8229

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we will be glad to help you. We look forward to working with you in maintaining your dental health.

Date _______________ Patient ID _______________

Patient Information

Name ____ Date of Birth ________________ Sex ☐ M ☐ F
Last Name First Name Middle Initial

Address ____ City ____________________ State _______ ZIP _________

Age _____ Phone __________________ Cell Phone _________________ Email________________________________

Preferred method of contact: ☐ Home Phone ☐ Cell Phone ☐ Email

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated SSN ______________________

Patient Employer ____ Occupation ____________________________

Employer/School Address ____

City _____________________________________ State _______ Zip _____________ Employer Phone ______________________

Who may we thank for referring you? ____

In case of an emergency who should be notified? ____

Responsible Party (if different from above)

Name ____ Date of Birth ________________
Last Name First Name Middle Initial

Address ____ City ____________________ State _______ ZIP _________

Phone ____________________ Cell Phone ____________________ Email ______________________________________

Driver's License # ______________________ Relationship __________________________________ SSN ___________________________

Is this person currently a patient in our office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full is due upon completion of each appointment.

☐ Cash ☐ Check ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy

Primary Insurance

Subscriber Name ____ Date of Birth ___________________
Last Name First Name Middle Initial

Relation to Patient ____ SSN ________________ Phone _______________

Address ____ City ____________________ State _______ ZIP___________

Subscriber Employer __________________________________ Occupation ______________________ Phone _________________

Employer Address _____________________________________ City ____________________ State _______ ZIP ___________

Insurance Company ___________________________________ Group # _____________________ Subscriber ID _______________________

Address ____________________________________ City ____________________ State ______ ZIP __________ Phone ____________

Secondary Insurance

Subscriber Name ____ Date of Birth ___________________
Last Name First Name Middle Initial

Relation to Patient ____ SSN ________________ Phone _______________

Address ____ City ____________________ State _______ ZIP___________

Subscriber Employer __________________________________ Occupation ______________________ Phone _________________

Employer Address _____________________________________ City ____________________ State _______ ZIP ___________

Insurance Company ___________________________________ Group # _____________________ Subscriber ID _______________________

Address ____________________________________ City ____________________ State ______ ZIP __________ Phone ____________

Patient Medical History

Physician ______________________________ Office Phone __________________________ Date of Last Exam ________________________

1. Are you under medical treatment now?......................... ☐ Yes ☐ No
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?.. ☐ Yes ☐ No
   If yes, please explain ______________________________
   ____
3. Are you taking any medications(s) including non-prescription medicine?.................................... ☐ Yes ☐ No
   If yes, what medication(s) are you taking? ______________
   ____
4. Have you ever taken Fen-Phen/Redux?............................... ☐ Yes ☐ No
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medication containing bisphosponates?............................... ☐ Yes ☐ No
6. Have you taken Viagra, Revatio, Cialis or Levitra In the last 24 hours?... ☐ Yes ☐ No
7. Do you use tobacco?.. ☐ Yes ☐ No
8. Do you use controlled substances?..................................... ☐ Yes ☐ No
9. Do you have any of the following:

High Blood Pressure………..	☐ Yes ☐ No	Heart Disease………………..	☐ Yes ☐ No	Chest Pains…………………	☐ Yes ☐ No
Heart Attack………………….	☐ Yes ☐ No	Cardiac Pacemaker………….	☐ Yes ☐ No	Easily Winded……………….	☐ Yes ☐ No
Rheumatic Fever…………….	☐ Yes ☐ No	Heart Murmur………………….	☐ Yes ☐ No	Stroke………………………..	☐ Yes ☐ No
Swollen Ankles………………	☐ Yes ☐ No	Angina………………………….	☐ Yes ☐ No	Hay Fever / Allergies ……..	☐ Yes ☐ No
Fainting / Seizures …………	☐ Yes ☐ No	Frequently Tired…..………….	☐ Yes ☐ No	Tuberculosis………………..	☐ Yes ☐ No
Asthma……………………….	☐ Yes ☐ No	Anemia……………………..….	☐ Yes ☐ No	Radiation Therapy…………	☐ Yes ☐ No
Low Blood Pressure………..	☐ Yes ☐ No	Emphysema……………………	☐ Yes ☐ No	Glaucoma…………..………	☐ Yes ☐ No
Epilepsy / Convulsions………	☐ Yes ☐ No	Cancer………………………….	☐ Yes ☐ No	Recent Weight Loss………..	☐ Yes ☐ No
Leukemia……………………..	☐ Yes ☐ No	Arthritis…………….………….	☐ Yes ☐ No	Liver Disease…….…………	☐ Yes ☐ No
Diabetes………………………	☐ Yes ☐ No	Joint Replacement or Implant..	☐ Yes ☐ No	Heart Trouble…………….....	☐ Yes ☐ No
Kidney Disease………………	☐ Yes ☐ No	Hepatitis / Jaundice…………..	☐ Yes ☐ No	Respiratory Problems………	☐ Yes ☐ No
AIDS or HIV Infection……….	☐ Yes ☐ No	Sexually Trasmitted Disease…	☐ Yes ☐ No	Mitral Valve Prolapse……….	☐ Yes ☐ No
Thyroid Problem……………..	☐ Yes ☐ No	Stomach Troubles / Ulcers……	☐ Yes ☐ No	Other ___________________	☐ Yes ☐ No

10. Are you wearing contact lenses?.......................... ☐ Yes ☐ No
11. Are you allergic to or have you had any reactions to the following?
    - Local Anesthetics (e.g. Novocain)………………………….. ☐ Yes ☐ No
    - Penicillin or any other Antibiotics…………………………... ☐ Yes ☐ No
    - Sulfa Drugs………………………………… ……………... ☐ Yes ☐ No
    - Barbiturates……………………………………………….... ☐ Yes ☐ No
    - Sedatives………………………………………………….. ☐ Yes ☐ No
    - Iodine……………………………………………………… ☐ Yes ☐ No
    - Aspirin……………………………………………............ ☐ Yes ☐ No
    - Any Metals (e.g. nickel, mercury, etc.)………………. …….. ☐ Yes ☐ No
    - Latex Rubber……………………………………………... ☐ Yes ☐ No
    - Other (please list)……………………………….............. ☐ Yes ☐ No
12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?............. ☐ Yes ☐ No
13. **Women Only:**
    - a) Are you pregnant or think you may be pregnant?.......... ☐ Yes ☐ No
    - b) Are you nursing?... ☐ Yes ☐ No
    - c) Are you taking oral contraceptives?.............................. ☐ Yes ☐ No

Dental History

Name of Previous Dentist and Location ____ Date of Last Exam ____________

1. Do your gums bleed while brushing or flossing?................... ☐ Yes ☐ No
2. Are your teeth sensitive to hot or cold liquids/foods?............ ☐ Yes ☐ No
3. Are your teeth sensitive to sweets or sour liquids/foods?....... ☐ Yes ☐ No
4. Do you feel pain to any of your teeth?.................................. ☐ Yes ☐ No
5. Do you have any sores or lumps in or near your mouth?....... ☐ Yes ☐ No
6. Have you had any head, neck or jaw injuries?...................... ☐ Yes ☐ No
7. Have you ever experienced any of the following Problems in your jaw?
   - Clicking…………………………………………………………. ☐ Yes ☐ No
   - Pain (joint, ear, side of face)…………………………………... ☐ Yes ☐ No
   - Difficulty in opening or closing………………………………… ☐ Yes ☐ No
   - Difficulty chewing……………………………………………….. ☐ Yes ☐ No
8. Do you have frequent headaches?........................... ☐ Yes ☐ No
9. Do you clench or grind your teeth?........................... ☐ Yes ☐ No
10. Do you bite your lips or cheeks frequently?............... ☐ Yes ☐ No
11. Have you ever had any difficult extractions in the past?.. ☐ Yes ☐ No
12. Have you ever had any prolonged bleeding following extractions?.. ☐ Yes ☐ No
13. Have you had any orthodontic treatment?................. ☐ Yes ☐ No
14. Do you wear dentures or partials?............................ ☐ Yes ☐ No
    If yes, date of placement ______________________
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?.............. ☐ Yes ☐ No
16. Do you like your smile?... ☐ Yes ☐ No

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental Care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible of all services rendered on my behalf of my dependents.

X____

Signature of patient (or parent/guardian if minor) Date

Doctor's Comments: ____

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