

Name: _____

Mid-Valley Dental Associates

Geoffrey A. Berg, DMD

Tyler L. Bryan, DMD

Steven M. Deming, DDS

Brian D. Tidwell, DDS

Birthdate: _____ Age: _____

DENTAL HISTORY

Albany Location

2825 Wiletta ST SW Suite A
Albany, OR 97321
(541) 928-2301

Eugene Location

1241 Oak Street
Eugene, OR 97401
(541) 686-9897

Philomath Location

2811 Main Street
Philomath, OR 97370
(541) 929-5227

Salem Location

3545 Lancaster Dr.
Salem, OR 97305
(503) 371-9897

Dallas Location

197 SE Washington
Dallas, OR 97338
(503) 623-2389

Reason for today's visit: _____

Former Dentist: _____ City: _____

Date of last dental visit: _____ Date of last dental X-rays: _____

Please check if you have or have had any of the following:

- | | | |
|---|---|---|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Sensitivity to sweets | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Sensitivity to hot & cold |
| <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Food collection between teeth |
| <input type="checkbox"/> Pain in mouth | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sores or growths in your mouth |

Are you satisfied with the appearance of your teeth? _____

Please rate your smile: 0 1 2 3 4 5 6 7 8 9 10

MEDICAL HISTORY

Physician's name: _____ Date of last physical: _____

Have you had any serious illness or operations? No / Yes If Yes, describe: _____

(Women) Are you pregnant? No / Yes Nursing? No / Yes Taking birth control pills? No / Yes

Do you require antibiotics prior to dental treatment? No / Yes

Please check if you have or have had any of the following:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Respiratory diseases |
| <input type="checkbox"/> Alzheimers,
dementia, memory loss | <input type="checkbox"/> Cortisone treatments | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Radiation treatment |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Artificial joints | <input type="checkbox"/> Cough, persistent | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Skin rash |
| <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Latex allergy | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Back problems | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Tobacco habit |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nervous problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemical
dependency | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Parkinson's disease | <input type="checkbox"/> Venereal disease |
| | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Psychiatric care | |

Other? Describe: _____

MEDICATIONS: _____

ALLERGIES: _____

AUTHORIZATION AND RELEASE:

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist benefits insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

Signature of patient, or of parent if patient is a minor _____

Date _____

Payment is due in full at time of treatment unless prior arrangements have been approved.

PATIENT INFORMATION

Patient's Name: _____ Birthdate: _____ Age: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Daytime phone: _____ Email: _____
How would you prefer to be contacted? Home _____ Work _____ Email _____ Mail _____
Is patient a student?: ___Y/N___ Name of school: _____
Whom may we thank for referring you to our office? _____

RESPONSIBLE PARTY INFORMATION

Name: _____ Marital Status: _____
Address: _____ City: _____ State: _____ Zip: _____
Mailing address: _____
How long at this address? _____ Home Phone: _____ Daytime Phone: _____
Relationship to Patient: _____ Birthdate: _____ Social Security No: _____
Employer: _____ Occupation: _____ No. Years Employed: _____
Spouse's Name: _____
Employer: _____ Occupation: _____ No. Years Employed: _____
Daytime Phone: _____ Birthdate: _____ Social Security No: _____

INSURANCE INFORMATION

Policy Holder's Name: _____ and Insurance ID No: _____
Insurance Company: _____ Group No: _____ Union Local No: _____
Insurance Co. Address: _____ Insurance Co. Phone: _____
Policy Holder's Employer: _____
Does the patient have dual coverage? ___No / Yes___ If Yes, please complete the information below.
Policy Holder's Name: _____ and Insurance ID No: _____
Insurance Company: _____ Group No: _____ Union Local No: _____
Insurance Co. Address: _____ Insurance Co. Phone: _____
Policy Holder's Employer: _____

EMERGENCY INFORMATION

Name of nearest relative not living with patient: _____
Complete address: _____
Phone No: _____ Relationship: _____

Patient Signature, or Parent's signature if patient is a minor

Date