Welcome to Bluestem Dental

We will strive to provide you with the best possible dental care. To help us meet your healthcare needs, please fill out this form completely. Health challenges you may have, or medications you take could have an impact on your dental care. Thank you for sharing this confidential information. – Dr. Anthony Hilleren and Dr. Marissa Goplen

Patient Information

Date _____
SS/HIC/Patient ID # _____
Patient Name _____
Address _____
City _____
State _____ Zip _____
E-mail _____
Sex ☐ M ☐ F Age _____ Date of Birth _____
Family Members _____
_____

Occupation _____
Patient Employer/School _____
Employer/School Address _____
_____
Employer/School Phone (____) _____
Spouse's Name _____
Date of Birth _____ SS# _____
Spouse's Employer _____
Whom may we thank for referring you? _____
Hobbies _____

Dental Insurance

Primary Insurance
Subscriber's Name _____
Relationship to Patient _____
Date of Birth _____ SS# _____
Insurance Co. _____
Group # _____ Phone (____) _____

Is patient covered by secondary insurance? ☐ Yes ☐ No
Subscriber's Name _____
Relationship to Patient _____
Date of Birth _____ SS# _____
Insurance Co. _____
Group # _____ Phone (____) _____

Phone Numbers

Home (____) _____ Work (____) _____ Ext _____ Alt. (____) _____
Spouse's Work (____) _____ Best time & place to reach you _____
In Case of Emergency (Specify someone who does not live in your household.) _____
Home (____) _____ Work (____) _____ Ext _____ Alt. (____) _____

Dental History

Reason for today's visit _____
_____
Former Dentist _____
City/State _____
Date of last dental visit _____
Date of last dental X-rays _____
How often do you floss? _____
How often do you brush? _____
Do you wear contact lenses? ☐ Yes ☐ No

Please check "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No	Jaw pain or tiredness	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No	Lip or cheek biting	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No	Loose teeth or broken fillings	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No	Mouth breathing	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No	Mouth pain	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No	Orthodontic treatment	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No	Pain around ear	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No	Periodontal treatment	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No	Sensitivity to cold	☐ Yes	☐ No
Food collection between teeth	☐ Yes	☐ No	Sensitivity to heat	☐ Yes	☐ No
Foreign objects in mouth	☐ Yes	☐ No	Sensitivity to sweets	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No	Sensitivity when biting	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No	Sores or growths in mouth	☐ Yes	☐ No

Thank You for Selecting Our Dental Team

Mark your response to indicate if you have had any of the following diseases or problems.
Mark don't know (DK) if you are unsure whether you have had the disease or problem.
If you have a disease or problem that is not listed blow, write the disease or condition in the space at the bottom of this form.

	Yes	No	DK
Do you have tuberculosis?	☐	☐	☐
Are you pregnant	☐	☐	☐

Physician: Name_____ Telephone _____

Address _____

Date of last physical Exam: _____

Yes	No	DK	
☐	☐	☐	Any changes in your health within the past year?
☐	☐	☐	High blood pressure
☐	☐	☐	Angina (chest pain)
☐	☐	☐	Heart attack
☐	☐	☐	Irregular heart beat
☐	☐	☐	Heart surgery
☐	☐	☐	Heart failure
☐	☐	☐	Damaged heart valve
☐	☐	☐	High cholesterol
☐	☐	☐	Heart infection
☐	☐	☐	Stroke
☐	☐	☐	Infective endocarditis
☐	☐	☐	Anemia
☐	☐	☐	Sickle cell anemia
☐	☐	☐	Abnormal bleeding
☐	☐	☐	Asthma
☐	☐	☐	Emphysema/bronchitis
☐	☐	☐	Sleep apnea
☐	☐	☐	Difficulty breathing
☐	☐	☐	Diabetes
☐	☐	☐	Thyroid problem
☐	☐	☐	Kidney disorder
☐	☐	☐	Dialysis
☐	☐	☐	Past use of steroids
☐	☐	☐	Delayed healing
☐	☐	☐	Arthritis
☐	☐	☐	Artificial joint
☐	☐	☐	Fibromyalgia
☐	☐	☐	Lupus
☐	☐	☐	Sjogren's Syndrome
☐	☐	☐	Osteoporosis
☐	☐	☐	Acid reflux/GERD
☐	☐	☐	Irritable bowel syndrome
☐	☐	☐	Stomach ulcer
☐	☐	☐	Liver disease
☐	☐	☐	Jaundice
☐	☐	☐	Hepatitis
☐	☐	☐	Epilepsy/seizures
☐	☐	☐	Parkinson's Disease
☐	☐	☐	Multiple sclerosis
☐	☐	☐	Headaches
☐	☐	☐	Hives or skin rash
☐	☐	☐	Other skin lesions
☐	☐	☐	Glaucoma
☐	☐	☐	Impaired vision
☐	☐	☐	Impaired hearing
☐	☐	☐	HIV positive/AIDS
☐	☐	☐	Sexually transmitted disease
☐	☐	☐	Bipolar disorder
☐	☐	☐	Depression
☐	☐	☐	Anxiety
☐	☐	☐	Eating disorders
☐	☐	☐	Sleep disorder
☐	☐	☐	Dementia
☐	☐	☐	Learning disorders
☐	☐	☐	Cancer
☐	☐	☐	Cancer treatment
☐	☐	☐	Nursing infant
☐	☐	☐	Tobacco use
☐	☐	☐	Alcohol use
☐	☐	☐	Chemical dependency
☐	☐	☐	Street/recreational/illicit drug use
☐	☐	☐	Bisphosphonate use
☐	☐	☐	Blood Thinners

Alergeries

☐	☐	☐	Local anesthetic
☐	☐	☐	Antibiotics
☐	☐	☐	Aspirin/ibuprofen
☐	☐	☐	Acetaminophen (Tylenol)
☐	☐	☐	Codeine/narcotics
☐	☐	☐	Metals
☐	☐	☐	Latex
☐	☐	☐	Other: _____

Please list any medications you are currently taking. _____

Please list any disease, condition, or problem you have that is not listed above._____

Please list any hospitalizations or surgeries you have had. _____

To the best of my knowledge, the preceding information is complete and correct.

_____ _____

Signature - Patient (or parent/guardian if patient is under 18) Date

MEDICAL UPDATES - I have received my Health History and confirm that it accurately states past and present conditions.

DATE	PATIENT SIGNATURE	CHANGES TO HEALTH HISTORY
_____	_____	_____
_____	_____	_____
_____	_____	_____