

**Molar King**

2859 E Fountain Blvd  
 Colorado Springs, CO 80910  
 Ph # : 719-358-6379  
 Fax # : 719-645-8320

**Patient Personal Information**

Title	Nickname	Birth Date	Age
Last, First		Marital Status	Sex
Address		Home #	Work #
		Cell #	Drive Lic
City, State, Zip		Emergency Contact	Emergency Phone #
Email		Student	SSN
Health Care Guardian Name		School Name	
Health Care Guardian Phone #		Referral Type	

**Person responsible/guarantor for paying bills**

Title	Nickname	Birth Date	Age
Last, First		Marital Status	Sex
Address		Home #	Work #
		Cell #	Drive Lic
City, State, Zip		SSN	
Email			

<b>Do you have Primary Dental Insurance?</b>	<b>Yes</b>	<b>No</b>	<b>Do you have Secondary Dental Insurance?</b>	<b>Yes</b>	<b>No</b>
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Group No/Name		Group No/Name	
Insurance Name		Insurance Name	
Phone #		Phone #	
Employer Name		Employer Name	
Subscriber Last, First		Subscriber Last, First	
Subscriber Address		Subscriber Address	
City, State, Zip		City, State, Zip	
Relationship to Patient	Birth Date	Relationship to Patient	Birth Date
Subscriber ID		Subscriber ID	

**Patient Medical Information**

<b>Allergic To</b>	<input type="checkbox"/> Y <input type="checkbox"/> N Anorexia	<input type="checkbox"/> Y <input type="checkbox"/> N Fainting Spells	<input type="checkbox"/> Y <input type="checkbox"/> N Persistent Diarrhea
<input type="checkbox"/> Y <input type="checkbox"/> N No Known Allergies	<input type="checkbox"/> Y <input type="checkbox"/> N Arteriosclerosis	<input type="checkbox"/> Y <input type="checkbox"/> N Fever Blisters	<input type="checkbox"/> Y <input type="checkbox"/> N Premedicate
<input type="checkbox"/> Y <input type="checkbox"/> N Aspirin	<input type="checkbox"/> Y <input type="checkbox"/> N Arthritis	<input type="checkbox"/> Y <input type="checkbox"/> N Frequent Headaches	<input type="checkbox"/> Y <input type="checkbox"/> N Radiation Treatment
<input type="checkbox"/> Y <input type="checkbox"/> N Barbiturates / Sleeping Pills	<input type="checkbox"/> Y <input type="checkbox"/> N Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N Frequently Dry Mouth / Sjogren	<input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic Fever
<input type="checkbox"/> Y <input type="checkbox"/> N Codeine	<input type="checkbox"/> Y <input type="checkbox"/> N Autoimmune Disease	<input type="checkbox"/> Y <input type="checkbox"/> N Gag Reflex	<input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic Heart Disease
<input type="checkbox"/> Y <input type="checkbox"/> N Erythromycin	<input type="checkbox"/> Y <input type="checkbox"/> N Bladder Trouble	<input type="checkbox"/> Y <input type="checkbox"/> N Gall Bladder Trouble	<input type="checkbox"/> Y <input type="checkbox"/> N Rheumatoid Arthritis
<input type="checkbox"/> Y <input type="checkbox"/> N Iodine	<input type="checkbox"/> Y <input type="checkbox"/> N Blood Clotting Problems	<input type="checkbox"/> Y <input type="checkbox"/> N Hay Fever	<input type="checkbox"/> Y <input type="checkbox"/> N Seizures
<input type="checkbox"/> Y <input type="checkbox"/> N Latex Rubber	<input type="checkbox"/> Y <input type="checkbox"/> N Blood Transfusion	<input type="checkbox"/> Y <input type="checkbox"/> N Heart Attack	<input type="checkbox"/> Y <input type="checkbox"/> N Sexually Transmitted Disease
<input type="checkbox"/> Y <input type="checkbox"/> N Local Anesthetics	<input type="checkbox"/> Y <input type="checkbox"/> N Bulimia	<input type="checkbox"/> Y <input type="checkbox"/> N Heart Disease	<input type="checkbox"/> Y <input type="checkbox"/> N Shortness of Breath
<input type="checkbox"/> Y <input type="checkbox"/> N Metals	<input type="checkbox"/> Y <input type="checkbox"/> N Bronchitis	<input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur	<input type="checkbox"/> Y <input type="checkbox"/> N Skin Rash
<input type="checkbox"/> Y <input type="checkbox"/> N No Epinephrine	<input type="checkbox"/> Y <input type="checkbox"/> N Cancer / Tumor or Growth	<input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis	<input type="checkbox"/> Y <input type="checkbox"/> N Sinus Trouble
<input type="checkbox"/> Y <input type="checkbox"/> N Penicillin	<input type="checkbox"/> Y <input type="checkbox"/> N Cardiac Pacemaker	<input type="checkbox"/> Y <input type="checkbox"/> N Herpes	<input type="checkbox"/> Y <input type="checkbox"/> N Stomach Ulcers
<input type="checkbox"/> Y <input type="checkbox"/> N Prior Hepatitis	<input type="checkbox"/> Y <input type="checkbox"/> N Cardiovascular Disease	<input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure	<input type="checkbox"/> Y <input type="checkbox"/> N Stroke
<input type="checkbox"/> Y <input type="checkbox"/> N Sulfa Drugs	<input type="checkbox"/> Y <input type="checkbox"/> N Chemotherapy	<input type="checkbox"/> Y <input type="checkbox"/> N Hives	<input type="checkbox"/> Y <input type="checkbox"/> N Thyroid Problems
<input type="checkbox"/> Y <input type="checkbox"/> N Other Narcotics	<input type="checkbox"/> Y <input type="checkbox"/> N Chest Pain Upon Exertion	<input type="checkbox"/> Y <input type="checkbox"/> N Jaundice	<input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis
<b>Check, if applicable</b>	<input type="checkbox"/> Y <input type="checkbox"/> N Color Blindness	<input type="checkbox"/> Y <input type="checkbox"/> N Joint Replacement	<input type="checkbox"/> Y <input type="checkbox"/> N Unusual Weight Loss
		<input type="checkbox"/> Y <input type="checkbox"/> N Kidney	

<input type="checkbox"/> Y <input type="checkbox"/> N No Change Since Last Recorded	<input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Defect	<input type="checkbox"/> Y <input type="checkbox"/> N Leukemia	<input type="checkbox"/> Y <input type="checkbox"/> N Urinate Frequently
<input type="checkbox"/> Y <input type="checkbox"/> N No Known Concerns or Issues	<input type="checkbox"/> Y <input type="checkbox"/> N Contact Lenses	<input type="checkbox"/> Y <input type="checkbox"/> N Liver Disease	<b>Other</b>
<input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Bleeding	<input type="checkbox"/> Y <input type="checkbox"/> N Congestive Heart Failure	<input type="checkbox"/> Y <input type="checkbox"/> N Low Blood Pressure	<input type="checkbox"/> Y <input type="checkbox"/> N See Scanned Documents: Pt Note
<input type="checkbox"/> Y <input type="checkbox"/> N AIDS/HIV Infection	<input type="checkbox"/> Y <input type="checkbox"/> N Damaged Heart Valve	<input type="checkbox"/> Y <input type="checkbox"/> N Lupus	
<input type="checkbox"/> Y <input type="checkbox"/> N Alcohol/Drug Abuse	<input type="checkbox"/> Y <input type="checkbox"/> N Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N Mental Health Problems	
<input type="checkbox"/> Y <input type="checkbox"/> N Angina	<input type="checkbox"/> Y <input type="checkbox"/> N Emphysema	<input type="checkbox"/> Y <input type="checkbox"/> N Mitral Valve Prolapse	
<input type="checkbox"/> Y <input type="checkbox"/> N Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N Environmental Allergies	<input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker	
<input type="checkbox"/> Y <input type="checkbox"/> N Ankles Swell	<input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy		

### Dental Questionnaire

#### Dental Questionnaire

Name of previous Dentist \_\_\_\_\_

Phone \_\_\_\_\_

Date of your last cleaning \_\_\_\_\_

Last exam date \_\_\_\_\_

Date of your last full series x-rays \_\_\_\_\_

Date of last cavity detection (bitewing) x-rays \_\_\_\_\_

Do your gums bleed while brushing or flossing ? \_\_\_\_\_

Are your teeth sensitive to hot, cold or sweets ? \_\_\_\_\_

Do you get frequent fever blisters, mouth ulcers, or sores on your lips or in your mouth ? \_\_\_\_\_

Have you ever had burning of the tongue or cracking of the corners of your mouth ? \_\_\_\_\_

Do you chew/smoke tobacco in any form ? \_\_\_\_\_

Have you had any head, neck or jaw injuries ? \_\_\_\_\_

Do you notice popping, clicking or soreness of the jaws or points just in front of the ears ? \_\_\_\_\_

Do you clench or grind your teeth ? \_\_\_\_\_

Have you ever had orthodontic treatment ? \_\_\_\_\_

If Yes, date of placement \_\_\_\_\_

Do you wear dentures or partials ? \_\_\_\_\_

If Yes, date of placement of dentures ? \_\_\_\_\_

Are you happy with your dentures ? \_\_\_\_\_

Are you having any specific problems with your teeth, gums, or mouth at this time ? \_\_\_\_\_

Are you happy with your smile ? \_\_\_\_\_

Do you have problems with teeth/fillings breaking ? \_\_\_\_\_

Do you regularly use dental floss ? \_\_\_\_\_

Do you have, or have you ever been told, that you have Pyorrhea (Periodontal Disease) ? \_\_\_\_\_

Do you have difficulty in opening your mouth widely ? \_\_\_\_\_

Do you have an unpleasant taste or odor in your teeth/mouth ? \_\_\_\_\_

Does food catch between your teeth ? \_\_\_\_\_

Do you want to learn to control your dental disease and retain your teeth ? \_\_\_\_\_

**Additional Comments**

Any Disease, Condition or Problem not Listed ? Please list \_\_\_\_\_

**Medical Questionnaire**

**Emergency Contact**

Emergency contact name \_\_\_\_\_

Emergency contact phone \_\_\_\_\_

Emergency contact relationship to patient \_\_\_\_\_

**Medical Questionnaire**

Family Physician \_\_\_\_\_

Phone \_\_\_\_\_

Are you currently under care of a Physician ? \_\_\_\_\_

If Yes, what is the condition being treated ? \_\_\_\_\_

Have you had any serious illness, operation or been hospitalized within the past 5 years ? \_\_\_\_\_

If Yes, what illness or problem ? \_\_\_\_\_

Are you currently taking any medication ? \_\_\_\_\_

If Yes, what ? \_\_\_\_\_

Have you taken bisphosphonates (Fosamax, Boniva, Zometa, Actonel, Didronel, Aredia, Skelid, Reclast) \_\_\_\_\_

Have you ever taken the diet control drug Fen-Phen ? \_\_\_\_\_

Do you use alcoholic beverages ? \_\_\_\_\_

Do you smoke ? \_\_\_\_\_

**Women Only**

Are you pregnant? \_\_\_\_\_

If Yes, what is your due date ? \_\_\_\_\_

Are you currently nursing ? \_\_\_\_\_

Do you have menstrual period problems ? \_\_\_\_\_

Are you on hormone replacement therapy ? \_\_\_\_\_

Are you on birth control pills / fertility drugs ? \_\_\_\_\_

**Additional Comments**

Any Disease, Condition or Problem not Listed ? Please list \_\_\_\_\_

By signing below, I certify that all of the above information is true to the best of my knowledge.

\_\_\_\_\_  
**Patient/Guardian Signature**

\_\_\_\_\_  
**Date**