

Dr. Ethan Moulton, DDS, MS
2375 E. Sunnyside Rd. Suite I
Idaho Falls, ID 83404

Ridge Crest

Dental Implants & Periodontics



208.522.6683 Ph • 208.552.3085 fax • www.ridgecrestperio.com

PATIENT INFORMATION

Patient Name: _____		
<i>Last</i>	<i>First</i>	<i>Middle Initial</i>
Preferred Name: _____		Birthdate: _____
Address: _____		
<i>Street</i>	<i>City</i>	<i>State</i> <i>Zip</i>
Phone: _____		
<i>Home</i>	<i>Cell</i>	<i>Work</i>
Email Address: _____		
How did you learn about our office? _____		Family Dentist: _____
If from a friend/relative, His/her name: _____		Social Security #: _____

EMERGENCY INFORMATION

Name of nearest relative not living with you: _____		
Full Address: _____		
<i>Street</i>	<i>State</i>	<i>Zip</i>
Phone: _____		
<i>Home</i>	<i>Cell</i>	

We appreciate that your time is valuable, as is ours. If you need to cancel an appointment, we ask that you kindly give us **two working days** notice. We do reserve the right to charge for cancellations or missed appointments.

Our Notice of Privacy Practice is available for review at any time in our office.



B	P

MEDICAL INFORMATION

Patient Name: _____ Regular Physician (M.D.): _____

Your Age: _____ Height: _____ Weight: _____ MM/YY of your last medical examination: _____

Preferred Pharmacy: _____ City: _____

How would you describe your Present Health (circle one) : Excellent | Good | Fair | Poor | Don't know

Y N (please check one)

- Have there been any change in your general health in the past year?
 - Have you ever had any problem with dental anesthetic in the past?
 - Have you had a serious illness, operation or hospitalization during the past five years?
If yes, Please describe: _____
 - Are you taking or have you recently taken any of the following:
Prescribed medications & inhalers: _____
Over the counter, natural or herbal preparations: _____
 - Have you ever received I.V., or taken orally: Zometa, Fosamax, Aredia or any other Bisphosphonates?
 - Have you ever taken prescription medications (Phen-fen/Phentermine) for weight loss?
 - Has your M.D. told you to take antibiotics prior to having any type of dental procedure?
 - Are you allergic to any medications or drugs, latex, iodine?
 - Have you ever had adverse reaction to any drugs, anesthetics, sedatives, narcotics, aspirin, Ibuprofen (Motrin)?
If you answered yes, please describe: _____
 - Have you ever had excessive bleeding that required special treatment?
 - Have you been diagnosed as having any immunodeficiency, systemic disease, ARC, HIV+, or aids?
 - Is there a history of diabetes in your family?
 - Are you required, due to health, to restrict your work or activity in anyway?
 - Are you on a special or restricted diet of any kind? No Yes _____
 - Do you use any kind of tobacco? If so, how much: _____ per day, week, month
 - Do you use any kind of alcohol? If so, how much: _____ per day, week, month
 - Do you have any history of substance abuse or do you currently use recreational drugs?
- For women, check all that apply: Pregnant Nursing Taking Birth control Pills

Check all of the following that you may have had in the past or that currently apply to you:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Chest Pain upon Exertion | <input type="checkbox"/> Cardiac Pacemaker | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Chronic Fatigue |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Stroke | <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Recurrent Infections | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Headaches or Migraines |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Impaired Liver Function | <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental Health Problems |
| <input type="checkbox"/> Heart Valve Prosthesis | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Neurological Disorders |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Impaired Kidney Function | <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Congenital Heart Lesion | <input type="checkbox"/> Joint Replacement Surgery | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis – Type A B C |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Esophageal Reflux | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Wear Contact Lenses |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Persistent Cough | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Damaged Heart Valve | <input type="checkbox"/> Anorexia or Bulimia | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Heart Arrhythmia | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Severely Impaired Vision |
| <input type="checkbox"/> Tachycardia | <input type="checkbox"/> Colitis | <input type="checkbox"/> Connective Tissue Disorder | |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> G.I. Ulcers | | |
- Received Blood Transfusion (Dates: _____)

Do you have any disease, problem or condition not listed above? Please explain: _____

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PATIENT NAME: _____

RESPONSIBLE PARTY INFORMATION

Name: _____
Last First Middle Initial

Residence: _____
Street City State Zip

Mailing Address: _____

How long at this address? _____ Rent or Own? _____ Monthly Rent or Mortgage: _____

Previous Address: _____
If less than 3 yrs. Street City State Zip

Social Security #: _____ Birthdate: _____ Relationship to Patient: _____

Employer: _____ Occupation: _____ No. Years Employed: _____

Home Phone: _____ Work Phone: _____

Spouse Name: _____

Spouse Employer: _____ Occupation: _____ No. Years Employed: _____

INSURANCE INFORMATION

Insured's Name: _____ Insured's Social Sec. # _____

Insurance Company: _____ Group# _____ ID# _____

Insurance Co. Address: _____
Street City State Zip

Do you have dual coverage? YES NO If Yes, Please fill out the following:

Insured's Name: _____ Insured's Social Sec. # _____

Insurance Company: _____ Group# _____ ID# _____

Insurance Co. Address: _____
Street City State Zip

Insured's Employer: _____

I understand that, where appropriate, credit Bureau reports may Be obtained

Signature of Patient or legal guardian:

Date:

Reviewed By: