Mary K. Parent, DMD, LLC
730 SE Oak, Suite C
Hillsboro, OR 97123

We are complimented that you have selected us to provide dental care for you and your family.
So that we can serve you better, please complete this patient history form.

A B C

PATIENT INFORMATION

Patient's Name Dr. Mr. Mrs. Miss Ms. _____
Last First Middle How do you wish to be addressed?

Address _____ City _____ State _____ Zip _____

Home Phone ( ) _____ Birth Date _____ SS # _____

If patient is a minor, give parent's or guardian's name _____

Who may we thank for referring you to our office? _____

E-mail Address _____ Cell Phone ( ) _____

RESPONSIBLE PARTY / BILLING INFORMATION

Name _____

Address _____ City _____ State _____ Zip _____

Mailing Address (if different from above) _____

How long at this address? _____ Home Phone _____ Work Phone _____ Ext. _____

Previous Address (if less than 3 years) _____ How long at this address? _____

SS # _____ Birth Date _____ Relationship to Patient _____

Employer _____ Occupation _____

Spouse's Name _____ Birth Date _____ SS # _____

Spouse's Employer _____ Occupation _____ Work Phone _____ Ext. _____

DENTAL INSURANCE INFORMATION

Insured's Name _____ Birth Date _____ Insured's SS # _____

Insurance Co. _____ Group No. _____ Local/Plan No. _____

Insurance Co. Address _____ Insurance Co. Phone ( ) _____

Insured's Employer _____

Do you have dual coverage? ☐ Yes ☐ No If Yes:

Insured's Name _____ Birth Date _____ Insured's SS # _____

Insurance Co. _____ Group No. _____ Local/Plan No. _____

Insurance Co. Address _____ Insurance Co. Phone ( ) _____

Insured's Employer _____

CONSENT FOR TREATMENT

I hereby authorize Mary K. Parent, D.M.D. to administer any treatment and to administer such x-rays, anesthetics, and to perform such dental procedures as may be deemed necessary or advisable in the diagnosis and treatment of my dental condition. I authorize release of any information relating to this claim. I realize that I am ultimately responsible for all cost of treatment. I understand the use of anesthetic agents embodies a certain risk. I hereby authorize my insurance benefits to be paid directly to Mary K Parent, D.M.D. and/or my provider of record.

DATE _____ SIGNATURE (patient or parent, for minor) _____

After initial x-rays and examination we will provide you an estimate of fees to cover your treatment at that time, financial arrangements will be made before treatment is rendered.

MEDICAL HISTORY

Physician's Name _____ Phone No. _____
How would you describe your health? _____ Date of last physical _____
Have you been hospitalized or under a physician's care in the last 2 years? _____ For? _____

Have you ever had an adverse reaction or allergies to any medication or substance?

❑ Aspirin ❑ Valium ❑ Sulfa Drugs ❑ Penicillin ❑ Novocaine ❑ Nitrous Oxide ❑ Latex
❑ Codeine ❑ Iodine ❑ Tetracycline ❑ Erythromycin ❑ Xylocaine ❑ Other _____

Have you ever had any of the following?

❑ Mitral valve prolapse
❑ High / low blood pressure
❑ Heart attack or stroke
❑ Heart murmur
❑ Rheumatic Fever
❑ Congenital heart problems
❑ Heart Valve or pacemaker
❑ Bleeding problem or anemia
❑ Blood disease
❑ Artificial joint
❑ Angina Pectoris
❑ Dizziness or fainting
❑ Diabetes
❑ Kidney or liver disease
❑ Ulcers or G.I. problems
❑ Thyroid problems
❑ Asthma or allergies
❑ Sinus problems
❑ Emphysema
❑ Respiratory disease
❑ Tuberculosis
❑ Hepatitis (Type:)
❑ Cancer
❑ X-ray or chemo therapy
❑ Arthritis or gout
❑ Glaucoma
❑ Epilepsy or seizures
❑ Hypoglycemia
❑ Drug / alcohol addiction
❑ Eating Disorder
❑ HIV-AIDS
❑ Venereal disease
❑ Cold sores / fever blisters
❑ Bruise easily
❑ Frequent thirst
❑ Freq. urination
❑ Use tobacco
❑ Now pregnant
❑ Surgery

Do you have any condition or problem not listed above which we should know about? Please explain:

_____

Please list ALL medications and drugs you are taking:

_____
_____
_____

DENTAL HISTORY

What are your present dental concerns? _____
When did you last see a dentist? _____ When did you last have dental x-rays? _____
Have you avoided regular dental care? ❑ Yes ❑ No If Yes, why? _____
Do you feel you have cavities? ❑ Yes ❑ No Do you feel you have gum disease? ❑ Yes ❑ No
Have you ever had periodontal (gum) treatments? ❑ Yes ❑ No
How often do you brush? _____ Floss? _____ Use other cleaning aids? _____
Are you happy with the appearance of your teeth? ❑ Yes ❑ No Would you like your teeth to be whiter? ❑ Yes ❑ No
What are your dental expectations? _____

Do you currently have problems with any of the following?

❑ Bleeding gums
❑ Bad breath
❑ Unpleasant taste
❑ Loose or chipped teeth
❑ Missing teeth
❑ Pain when chewing
❑ Jaw(s) clicking or popping
❑ Headaches or neck pain
❑ Grinding or clenching of teeth
❑ Sore areas in the mouth
❑ Frequent tooth or fillings breaking
❑ Teeth sensitive to pressure
❑ Hot / cold tooth sensitivity
❑ Sweet sensitive teeth
❑ Other _____

Previous dentist? _____ City _____ State _____
Would you like us to request your records from your previous dentist? ❑ Yes ❑ No Date of last cleaning _____
My previous dental experience has been ❑ Positive ❑ Neutral ❑ Negative

EMERGENCY INFORMATION

Name of nearest relative not living with you _____
Complete Address _____
City _____ State _____ Zip _____
Home Phone No. _____ Work Phone No. _____

THANK YOU