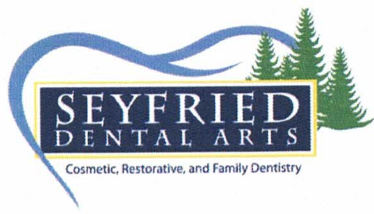

James W. Seyfried, DDS
1624 Library Lane
Minden, NV 89423
Phone: (775) 782-8176 Fax: (775) 783-9176
Email:Seyfried1624@gmail.com

Patient's Name: ______________________ Male ☐ Female ☐ DOB: __________

Mailing Address (including Street, City, State and Zip):

____

SSN: ______________ Phone Number: ______________

Employer: ______________ Occupation: ______________

Cell Phone: ______________ Work Phone: ______________

Full Name of Spouse, if applicable: ______________ Email: ______________

Who may we thank for referring you? ______________

Person to contact in case of emergency: ______________ Phone: (   ) ______________

Dental Insurance? No☐ Yes ☐ **(If yes, Please complete the following information and present your card to Receptionist)**

Insurance Company Name: ______________ Company Phone: ______________

Address: ____

Subscriber's Name: ______________ Relationship to Patient: ______________

DOB: __________ SSN or ID Number: __________ Group Number: __________

Secondary Dental Insurance? **No ☐ Yes ☐ (If yes, Please complete the following information)**

Subscriber's Name: ______________ #2 Insurance Company Name: ______________

Company Phone: ____

Address: ______________________________ DOB: __________

SSN or ID Number: ______________ Group Number: ______________

Consent

The undersigned hereby authorizes Doctor to take radiographs, study models, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication, and therapy, that may be indicated in connection with this patient, and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand the responsibility for payment (for dental services provided in this office for myself or my dependents) is mine, and is due and payable at the time services are rendered, unless previous arrangements have been made. I the undersigned, have given the above information, have reviewed it and find it accurate. If there are any later changes to this history record, I will so inform this practice. I hereby authorize necessary credit information to be obtained by your office.

HIPAA – Health Insurance Portability and Accountability Act

I have been informed/received a copy of the Notice of Privacy Practices for Protected Health Information.

______________________________ ______________

Signature (Patient/Responsible Party) Date

CONFIDENTIAL

THANK YOU FOR YOUR COOPERATION IN SUPPLYLING THE ABOVE INFORMATION

Medical Information

Name of Physician: ______________________ City: ______________ Phone: ____________

Date of last medical exam: ______________________ Are you pregnant? No ☐ Yes ☐ Due: ____________

Do you have current medical problems? No ☐ Yes ☐ If yes, please state: ____________________________

Have you ever had or do you have any of the following? (Please circle any that apply)

Hepatitis
Liver Disease
Jaundice
Rheumatic Fever
Diabetes
High Blood Pressure
Heart Problems, type: __________
Heart Murmur
Shortness of Breath
Stroke, when: __________
Blood Trouble/Anemia/Leukemia
Allergy/Hay Fever
Sinus
Do you use street drugs:__________
OTHER: ____________________________

Lung Trouble/Asthma/ TB/ Emphysema
Arthritis
Fainting spells/ Epilepsy/ Convulsions/ Dizziness
Nervous Breakdown
X-ray/ Indium or Cobalt treatment
Tumor or Cancer, type: ______________
Prosthetic Joint Replacement
HIV Infection
Autoimmune Disease
Kidney Disease
Head Injury
Glaucoma
Bone loss and taking Bisphosphonate Drugs
History of Drug Dependency?________________________

Are you now taking medicines for: (please specify medication)

Pain ______________
Nerves ______________
Sleeping ______________
Blood (thinners, other) ______________
Stomach ____________________
Thyroid ______________

Heart ______________________
Headaches ____________________
Arthritis ______________________
Allergy ______________________
Birth Control __________________
OTHER: ________________________

Have you ever shown an allergy to, been sick from, or been told not to take:

Antibiotics: ________________
Narcotics: __________________
Aspirin

Anesthetic: ____________
Other medications: ______________
Latex Allergy

Have you been told you need to PREMEDICATE before dental appointments by a doctor? _____

Do you have any disease, condition, or problem that is not mentioned above? ______________

Dental History

Reason for this visit ____

Previous Dentist: ________________________ Date last treated: ______________

Date of Last dental x-rays____________________

Have you ever had orthodontic treatment? Yes ☐ No ☐

Have you ever had dental extractions? Yes ☐ No ☐

Have you ever had periodontal (gum) surgery? Yes ☐ No ☐

Have you noticed any loosening of your teeth? Yes ☐ No ☐

Do your gums bleed often when you brush your teeth? Yes ☐ No ☐

Have you ever experienced clicking of the jaw or pain in the joint? Yes ☐ No ☐

Do you clench or grind your teeth while asleep or awake? Yes ☐ No ☐

Do you have fear or anxiety related to dental treatment? Yes ☐ No ☐

Are you unhappy with the appearance of your teeth? Yes ☐ No ☐

I, the undersigned, have given the above information, have reviewed it and find it accurate. If there are any later changes, I will so inform this practice.

______________________________ Signature

______________________________ Date

CONFIDENTIAL

THANK YOU FOR YOUR COOPERATION IN SUPPLYLING THE ABOVE INFORMATION