Daniel S. Poulson, DDS______________________
Family Dentistry
2180 East 4500 South #270
Holladay, UT 84117 (801) 278-8481

Patient Information: **Date**: _________ _____________
Patient's Name____
Patient's Address: ____
City: _______________________ State __________ Zip ___________
Home Phone: ______________ Cell: _________________ Business Phone: _____________
Business Address: ___________________City: ______________ State ______ Zip _______
Birth Date: _____________ Age: ______ Marital Status: S M D W Social Sec # ___________
Spouse's Name _____________________ Email Address ____________________________
Whom may we thank for referring you? ____

Person Responsible for Payment
Name: _________________________________ Social Security: _______________________
Home Address: ____
City: _______________________ State __________ Zip ___________
Relationship to Patient: __________________________ Occupation: ____________________
Employer: ____
Business Address: ___________________City: _______________State _____Zip_________
Name of nearest relative not living with you ____
Address: ____Phone ___________

Dental Benefit (Insurance) **Information**
Employee's Name: __________________________________ Birth Date: ______________
Employee's Social Security Number: ____
Name of Carrier: ____
Carrier's Address: ____
Program/Policy Number: _______________________ Group # ________________________
Do you have secondary Coverage? Y / N?
If so, with whom: ____

Acknowledgement and Authority
I consent to treatment as necessary for the patient named above, including but not restricted to whatever drugs, medications, materials, performance of operation and conduct of laboratory, x-rays, or other studies that may be used by the attending dentist, his assistants, or qualified designate. I also herby acknowledge I have received and reviewed the Office Privacy Policy Notice as called for by HIPPAA and accept and agree to this policy. I acknowledge full responsibility for the payment of services provided by this office to me and agree to pay them in full AT THE TIME OF SERVICE unless other arrangements are previously made with the financial administrator. In the event that the patient or responsible party shall not pay when due and the account must be referred for collection, patient or responsible party agrees to pay ALL the cost and expenses of collection whether litigation is required or not, including a reasonable attorney's fee.

Signed: ________________________________ **Date:** ___________________
Patient, Parent, Guardian, or Responsible Party (18 years of age or older)

Medical History

When was your last complete physical examination by your physician? ___________________
Your Physician's name _________________________________ Phone #_________________
Address: ____

Circle any of the following you presently have or have had in the past:

Heart Disease	**Psychiatric Treatment**	**Allergies:**
High Blood Pressure	**Arthritis**	**Penicillin**
Blood Disorders (anemia)	**Tumor History**	**other antibiotics: __________**
Rheumatic Fever	**Venereal Diseases (STD)**	**Codeine, Aspirin**
Heart Murmur	**Sinus Infection Problems**	**Local Anesthetics**
Thyroid Disease	**Ulcers**	**Other: _______________**
Diabetes	**Radiation Treatment**	**Asthma**
Stroke	**Live/Kidney Disease**	**Tuberculosis, Emphysema**
Epilepsy	**Hepatitis, Jaundice**	**Osteoporosis**
Fainting	**HIV Pos**	**Do you smoke? Y/N**
Artificial Joints/ Heart Valves	**Cancer**	**Would you like to quit? Y/N**

Have you ever taken: Fen Phen or other medication that have potentially damaged your heart?
Bisphosphonates (Fosamax, Boniva, etc.) for Osteoporosis or bone Cancer

____

____

Are you pregnant? Y/N Do you suspect that you might be? Y/N
What medications are you currently taking (include Herbal preparations and "over the counter" drugs):
____
Is there anything else we should know about your health history? ______________________________

Dental History

The purpose of your visit with us today: ____
How long since your last dental visit? _____________________What was it for?__________________
Name of your previous dentist: ____

Are your teeth sensitive? Y/N Which one(s): ____
To cold? Y/N To hot? Y/N To sweets? Y/N To pressure/chewing? Y/N

How often do you brush your teeth? ________________ Floss? ______________________________
Do your gums bleed when you brush and/or floss? Y/N If yes, how often does that occur? ________

Are you happy with the way your teeth look? Y/N If not, what would you change________________
Would you like them straighter? Y/N More even? Y/N
Would you like them to be whiter/ brighter? Y/N

Are any of your teeth painful when you chew on them? Y/N If yes, how often does that occur?______
Which teeth: ____

Do you clench or grind your teeth? Y/N
Have you experienced any pain /soreness in the muscles of your face, jaw, or around your ears? Y/N
Does your jaw click or pop when you chew? Y/N If yes, which side? R L Both side

Have you had any unpleasant dental experiences? Is there anything else we should know to make your dental care more pleasant experience for you? ______________________________________

I certify that the above information is complete and accurate to the best of my knowledge.
Signed: ______________________________________ Date: ________________________________