1250 Ironwood Drive • Suite 216
Coeur d' Alene, ID 83814

CORY HARKER D.D.S.
NORTHWEST
Natural Dentistry
PLLC

(208) 667-4844
www.NWNaturalDentistry.com

Thank you for choosing our office. In order to serve you properly, please answer all questions on BOTH sides, so that we may diagnose your oral health as accurately as possible. All information will be kept strictly confidential.

PATIENT'S NAME_____PREFERRED NAME _____

❑ Male ❑ Female Social Security No._____-_____-_____Birthdate_____/_____/_____

Mailing Address_____Email _____

City_____State_____Zip Code_____Home Phone No. (_____) _____

Cell Phone No. (_____)_____ How should we contact you? ❑ Home ❑ Cell ❑ Work ❑ Email

❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed

Patient Occupation_____Employer_____Work Phone (_____) _____

Name of Spouse_____ Birthdate_____/_____/_____ SSN _____

Spouse Occupation_____Employer_____Work Phone (_____) _____

IN CASE OF EMERGENCY, WHOM MAY WE CONTACT? (Other than someone living with you)

Name_____Home Ph. No. (_____)_____Work Ph. No. (_____) _____

Relationship to patient _____

WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

Payment Is Expected At Time Of Each Visit

Please Check Method of Payment

❑ Cash ❑ Check ❑ Bankcard ❑ Insurance

Person responsible for payment: _____

Primary Dental Insurance

Employee _____
Relationship to Patient _____
Employer _____
Insurance Co._____Group#_____
Insurance Phone No. _____
Employee's SSN _____
Subscriber D.O.B. _____

Secondary Dental Insurance

Employee _____
Relationship to Patient _____
Employer _____
Insurance Co._____Group#_____
Insurance Phone No. _____
Employee's SSN _____
Subscriber D.O.B. _____

I have been given and understand the HIPPA Notices of Privacy Act.

Signature_____Date _____

(Turn Page Over)

Dental History

Are you having any pain or discomfort at this time? ❑ Yes ❑ No
Are you nervous about having dental treatment? ❑ Yes ❑ No
Have you ever had a bad dental experience? ❑ Yes ❑ No
Do you experience difficulty / pain when chewing, talking or using your jaw? ❑ Yes ❑ No
Do you have noises in your jaw joint? ❑ Yes ❑ No
Does your bite feel uncomfortable or unusual? ❑ Yes ❑ No
Have you ever had an injury to your head or jaw? ❑ Yes ❑ No
Have you been treated for a jaw joint problem? ❑ Yes ❑ No
Chief dental concern:_____

Do you have dry mouth? ❑ Yes ❑ No
Do your teeth ever feel loose? ❑ Yes ❑ No
Does food often catch in-between your teeth? ❑ Yes ❑ No
Do your gums bleed? ❑ Yes ❑ No
Have you ever had periodontal (gum) disease? ❑ Yes ❑ No
Are your teeth sensitive to cold/heat/sweets? ❑ Yes ❑ No
Do you take antibiotics for a health condition before each dental visit? ❑ Yes ❑ No
Previous Dentist's Name and Location:_____

Are you happy with the way your smile looks? ❑ Yes ❑ No
If not, what would you change?_____

Health History

Do you smoke or use chewing tobacco (please circle one) ❑ Yes ❑ No
Have you been hospitalized or seen a Medical Doctor in the past 2 years? ❑ Yes ❑ No
*If so, for what condition?*_____
WOMEN: Are you pregnant or nursing? ❑ Yes ❑ No
Do you have a personal Physician? ❑ Yes ❑ No
*Physician's Name:*_____
*Date of last visit:*_____
*Reason for visit:*_____

Are you currently taking any prescriptions, over the counter drugs or herbal supplements? ❑ Yes ❑ No
If so, please list and include the reason for taking:

Have you ever taken Phen/fen, Redux or other diet related drugs? ❑ Yes ❑ No
Please list any serious medical condition(s) that you currently have or have had in the past:_____

Please Check any of the following which you have now or have had in the past.

❑ **No medical conditions**
❑ Angina Pectoris (Chest Pain)
❑ Heart Disease/Attack/Stroke
❑ Heart Failure
❑ High/Low Blood Pressure
❑ Congenital Heart Defect
❑ Heart murmur/Rheumatic Fever
❑ Heart Surgery
❑ Heart Pacemaker
❑ Artificial Heart Valve
❑ Diabetes, Type I ❑ II ❑
❑ Blood Transfusion/Anemia
❑ High Cholesterol Disease
❑ Bruise Easily
❑ Hemophilia/Blood Disorder/Sickle Cell
❑ Liver Disease/Yellow Jaundice
❑ Kidney Failure/Dysfunction
❑ Thyroid Disease/Condition
❑ Ulcers
❑ Glaucoma
❑ Cosmetic surgery_____
❑ Chemotherapy for Cancer
❑ X-ray Treatment for Cancer
❑ Tuberculoses (TB)
❑ Arthritis/Rheumatism/Lupus
❑ Cortisone Medicine/Steroids
❑ Venereal Disease/STDs
❑ A.I.D.S./H.I.V.
❑ Hepatitis: A, B, C (Circle any that apply.)
❑ Frequent Headaches
❑ Artificial Joints (Hip, Knee, etc.)
❑ Canker Sores/Cold Sores
❑ Fainting/Dizzy Spells
❑ Epilepsy/Seizures
❑ Hay Fever/Sinus Trouble
❑ Allergies/Hives
❑ Shingles
❑ Anxiety Disorder
❑ Psychiatric Treatment
❑ Drug/Alcohol Addiction
❑ Emphysema/Asthma
❑ Depressed Immune System
❑ Organ Transplant
❑ Osteoporosis
❑ Other_____

Are you allergic to or have you reacted adversely to any of the following?

Please check any that apply.

❑ Aspirin ❑ Demerol ❑ Valium ❑ Nitrous Oxide ❑ Erythromycin ❑ Other Antibiotics ❑ Metals/Jewelry
❑ Codeine ❑ Percodan ❑ Sulfa ❑ Penicillin ❑ Tetracycline ❑ Latex ❑ Local Anesthetic

*List any other allergies here:*_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment or amount that my insurance does not cover.

Patient Signature_____**Date**_____

Doctor Signature_____**Date**_____

Update Record

Date	Initial