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

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_____
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: _____