Scott L. Featherstone DDS, PLLC
191 Fifth Street West, 2nd Floor
P.O. Box 1328
Ketchum, ID 83340

Thank you for selecting our office for your continuing dental care.
To help us meet all your healthcare needs, please fill out this form completely in ink.
If you have any questions, or need assistance, please ask us and we will be happy to help.

PATIENT INFORMATION (Confidential)
Name ______________________________ Today's Date ____________
Soc. Sec. # ____________ Birth Date ____________ Home Phone ____________
Address ________________ City ____________ State ______ ZIP ________
Email ______________________________ Cell Phone ____________
If Student, Name of School _____ ________ City ________ State ____ ☐ Full Time ☐ Part Time
Patient or Parent/Guardian's Employer ________________ Work Phone ____________
Business Address ________________ City ________ State ______ ZIP ________
Spouse or Parent/Guardian's Name __________ Employer __________ Work Phone ________
Whom May We Thank for Referring You? ______________________________
Person to Contact in Case of Emergency ____________________ Phone ____________

RESPONSIBLE PARTY
Name of Person Responsible for this Account ________________ Relationship to Patient ____________
Address ______________________________ Home Phone ____________
Email ______________________________ Cell Phone ____________
Driver's License # ________________ Birth Date ____________
Employer ________________ Work Phone ____________ SS#________________
Is this Person Currently a Patient in our Office? ☐ Yes ☐ No
For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment is expected each visit.
☐ Cash ☐Personal Check Credit Card: ☐ VISA/MC ☐ AMEX ☐ Discover
☐ I wish to discuss other options

DENTAL INSURANCE INFORMATION
Name of Subscriber ______________________________ Relationship to Patient ____________
Birth Date ________ SS# ________ Employer ________________ Work Phone ____________
Insurance Company ________________ Group # ____________ Policy ID # ____________
Ins. Co. Address ________________ City ____________ State ______ ZIP ________
Ins. Co. Phone ____________
DO YOU HAVE ADDITIONAL DENTAL INSURANCE? ☐ Yes ☐ No If Yes, Complete the Following
Name of Subscriber ______________________________ Relationship to Patient ____________
Birth Date ________ SS# ________ Employer ________________ Work Phone ____________
Insurance Company ________________ Group # ____________ Policy ID # ____________
Ins. Co. Address ________________ City ____________ State ______ ZIP ________
Ins. Co. Phone ____________

Please answer questions regarding your health history on the next page

PATIENT MEDICAL HISTORY

Physician ________________________________ Office Phone____________ Last Exam ____________

1. Are you under medical treatment now? Y N
2. Have you been hospitalized in the last 5 years? Y N
   If yes, please explain ______________________
   ____
   ____
3. Are you taking any medications? Y N
   If yes, what are you taking __________________
   ____
   ____
   ____
4. Have you ever taken Fen-Phen/Redux? Y N
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications with bisphosphonates? Y N
6. Have you taken Viagra, Revatio, Cialis, or Levitra in the last 24 hours? Y N
7. Do you use tobacco? Y N
8. Do you use controlled substances? Y N
9. Are you wearing contact lenses? Y N
10. Are you allergic or reactive to the following?
    - Local anesthetic (e.g. Novocaine) Y N
    - Penicillin or other antibiotic Y N
    - Sulfa drugs Y N
    - Barbiturates Y N
    - Sedatives Y N
    - Iodine Y N
    - Aspirin Y N
    - Any Metals (nickel, mercury, etc.) Y N
    - Latex rubber Y N
    - Other ____________________ Y N
11. Do you have a persistent cough or throat clearing not associated with a known illness lasting more than 3 weeks? Y N
12. Women Only:
    - Are you pregnant or think you may be? Y N
    - Are you nursing? Y N
    - Are you taking oral contraceptives? Y N

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? Circle Y or N

High Blood Pressure	Y	N	Heart Disease	Y	N	Chest Pain	Y	N
Heart Attack	Y	N	Cardiac Pacemaker	Y	N	Easily Winded	Y	N
Rheumatic Fever	Y	N	Heart Murmur	Y	N	Stroke	Y	N
Swollen Ankles	Y	N	Angina (heart pain)	Y	N	Hay Fever/Allergies	Y	N
Fainting/Seizures	Y	N	Frequently Tired	Y	N	Tuberculosis	Y	N
Asthma	Y	N	Anemia	Y	N	Radiation Therapy	Y	N
Low Blood Pressure	Y	N	Emphysema	Y	N	Glaucoma	Y	N
Epilepsy/Convulsions	Y	N	Cancer	Y	N	Recent Weight Loss	Y	N
Leukemia	Y	N	Arthritis	Y	N	Liver Disease	Y	N
Diabetes	Y	N	Joint Replaced/Implant	Y	N	Heart Trouble	Y	N
Kidney Disease	Y	N	Hepatitis/Jaundice	Y	N	Respiratory Problems	Y	N
AIDS or HIV infection	Y	N	Sexually Trans Disease	Y	N	Mitral Valve Prolapse	Y	N
Thyroid Problems	Y	N	Stomach Trouble/Ulcers	Y	N	Other _____________	Y	N

PATIENT DENTAL HISTORY

Name of Previous Dentist ______________________________________ Date of Last Exam ______________

Previous Dentist Location ______________________________________ Date of Last Cleaning ______________

1. Do your gums bleed while brushing or flossing? Y N
2. Are your teeth sensitive to hot or cold liquids/foods? Y N
3. Are your teeth sensitive to sweet or sour liquids/foods? Y N
4. Do you feel pain in any of your teeth? Y N
5. Do you have any sores or lumps in or near your mouth? Y N
6. Have you had any head, neck or jaw injuries? Y N
7. Have you ever experienced any of the following problems in your jaw? Circle all that apply
   Clicking Popping Pain: joint, ear, face Difficulty chewing
   Difficulty in opening or closing your jaw
8. Do you like the appearance of your teeth and smile? Y N

8. Do you have frequent headaches? Y N
9. Do you clench or grind your teeth? Y N
10. Do you bite your lips or cheeks? Y N
11. Have you had difficult extractions in the past? Y N
12. Have you ever had any prolonged bleeding following extractions? Y N
13. Have you had any orthodontic treatment? Y N
14. Do you wear dentures or partial dentures? Y N
    If yes, date of placement ____________________
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? Y N

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X____ Date ________________

Signature of patient (or parent/guardian if patient a minor under age 18)

Doctor's Comments ____

____ Initials ____________ Date ____________