two rivers dentistry
vancouver, washington

Dr. Vaughn Teuscher
2415 SE 165th Ave. Suite 102 98683

welcome to our dental office

1. The Patient

Name_____Soc Sec. #_____
Last First Initial

Address_____
City State Zip

Home Phone_____ Work Phone _____Email_____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Employer_____Occupation_____

Business Address_____Business Phone_____

Spouse's Name_____ Spouse's Employer _____ Spouse's Work#_____

Whom may we thank for referring you?_____

Notify in case of emergency_____ Home Phone_____

2. Insurances

Primary Insurance

Person responsible for Account_____
Last name First Name Initial

Relation to Patient_____Birthdate_____Soc Sec.#_____

Address (if different from patient)_____Home Phone_____

City_____State_____Zip_____

Person responsible employed by_____Occupation_____

Business Address_____Bus Phone_____

Insurance Company_____Phone_____

Contract#_____ Group#_____ Subscriber#_____

Name of other dependents on this plan_____

Secondary Insurance

Subscriber Name_____ Relation to Patient _____Birthdate_____

Address (if different from patient_____

City_____State_____Zip_____

Subscriber employed by_____Business Phone_____

Insurance Company_____Phone_____

Contract#_____Group#_____Subscriber#_____

Name of other dependents on this plan_____

3. Dental History

Why have you come to the dentist today?_____

Former Dentist_____Address_____

Date of last Dental Care _____Date of Last Xrays_____

Please check if you have any of the following problems:

☐ Bad Breath	☐ Food collection between teeth	☐ Periodontal Treatment	☐ Sensitivity to Sweets
☐ Bleeding gums	☐ Teeth Grinding	☐ Sensitivity to Cold	☐ Sensitivity to Biting
☐ Clicking or popping jaw	☐ Loose Teeth or broken fillings	☐ Sensitivity to Hot	☐ Sores/growths in mouth

How often do you brush?_____Floss?_____

How do you feel about the appearance of you teeth?_____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? GY GN

Other information about your dental health or previous treatment_____

4. Medical History

Are you currently under a physician's care? If so, why_____

Physician's Name_____Phone_____

Have you had any serious illnesses or operations? If yes, describe_____

Do you have or have you ever had any of the following diseases or medical conditions?

☐ Y ☐ N Heart Attack/Stroke	☐ Y ☐ N Kidney Problems	☐ Y ☐ N Cancer/Tumor	☐ Y ☐ N Chemotherapy
☐ Y ☐ N Heart Surgery	☐ Y ☐ N Pacemaker	☐ Y ☐ N Asthma	☐ Y ☐ N Sinus Problems
☐ Y ☐ N Heart Murmur	☐ Y ☐ N Respiratory Problem	☐ Y ☐ N Hepatitis	☐ Y ☐ N Diabetes
☐ Y ☐ N Heart Disease	☐ Y ☐ N Ulcer	☐ Y ☐ N HIV+/AIDS	☐ Y ☐ N Leukemia
☐ Y ☐ N Rheumatic Fever	☐ Y ☐ N Psychiatric problems	☐ Y ☐ N Anemia	☐ Y ☐ N Arthritis/Rheumatism
☐ Y ☐ N Mitral Valve Prolapse	☐ Y ☐ N Venereal Disease	☐ Y ☐ N Emphysema	☐ Y ☐ N Frequent Neck Pain
☐ Y ☐ N Artificial Valves	☐ Y ☐ N Tuberculosis (TB)	☐ Y ☐ N Glaucoma	☐ Y ☐ N Severe Headaches
☐ Y ☐ N Artificial Bones/Joints	☐ Y ☐ N Scarlet Fever	☐ Y ☐ N Chest Pain	☐ Y ☐ N Seizures/Epilepsy
☐ Y ☐ N H/L Blood Pressure	☐ Y ☐ N Back Problems	☐ Y ☐ N Fainting	☐ Y ☐ N Alcohol/Drug Abuse
☐ Y ☐ N Congenital Heart Defect	☐ Y ☐ N Fever Blister/Herpes	☐ Y ☐ N Shingles	☐ Y ☐ N Jaw Problems/TMD

Allergies? ☐ None ☐ Latex ☐ Penicillin ☐ Aspirin ☐ Metals ☐ Acrylic ☐ Local Anesthetic ☐ Other_____

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No If yes, how much/how long_____

Have you ever taken the drug Phen-fen and/or Redux? ☐ Yes ☐ No

Women: Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Are you currently taking any medications? If yes, list all: _____
_____

Is there any other dental or medical information we should be aware of? _____
_____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status or insurance changes.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature_____Date_____