Dr. Ethan Moulton, DDS, MS
2375 E. Sunnyside Rd. Suite I
Idaho Falls, ID 83404

Ridge Crest
Dental Implants & Periodontics

208.522.6683 Ph • 208.552.3085 fax • www.ridgecrestperio.com

PATIENT INFORMATION

Patient Name: _____ (Last) _____ (First) _____ (Middle Initial)

Preferred Name: _____ Birthdate: _____

Address: _____ (Street) _____ (City) _____ (State) _____ (Zip)

Phone: _____ (Home) _____ (Cell) _____ (Work)

Email Address: _____

How did you learn about our office? _____ Family Dentist: _____

If from a friend/relative, His/her name: _____ Social Security #: _____

EMERGENCY INFORMATION

Name of nearest relative not living with you: _____

Full Address: _____ (Street) _____ (State) _____ (Zip)

Phone: _____ (Home) _____ (Cell)

We appreciate that your time is valuable, as is ours. If you need to cancel an appointment, we ask that you kindly give us ***two working days*** notice. We do reserve the right to charge for cancellations or missed appointments.

Our Notice of Privacy Practice is available for review at any time in our office.

CONT'D NEXT PAGE

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MEDICAL INFORMATION

Patient Name: _____ Regular Physician (M.D .): _____

Your Age: _____ Height: _____ Weight: _____ MM/YY of your last medical examination: _____

Preferred Pharmacy: _____ City: _____

How would you describe your Present Health (circle one) : Excellent | Good | Fair | Poor | Don't know

Y N (please check one)

❑ ❑ Have there been any change in your general health in the past year?
❑ ❑ Have you ever had any problem with dental anesthetic in the past?
❑ ❑ Have you had a serious illness, operation or hospitalization during the past five years?
If yes, Please describe: _____
❑ ❑ Are you taking or have you recently taken any of the following:
Prescribed medications & inhalers: _____
Over the counter, natural or herbal preparations: _____
❑ ❑ Have you ever received I.V., or taken orally: Zometa, Fosamax, Aredia or any other Bisphosphonates?
❑ ❑ Have you ever taken prescription medications (Phen-fen/Phentermine) for weight loss?
❑ ❑ Has your M.D. told you to take antibiotics prior to having any type of dental procedure?
❑ ❑ Are you allergic to any medications or drugs, latex, iodine?
❑ ❑ Have you ever had adverse reaction to any drugs, anesthetics, sedatives, narcotics, aspirin, Ibuprofen (Motrin)?
If you answered yes, please describe: _____
❑ ❑ Have you ever had excessive bleeding that required special treatment?
❑ ❑ Have you been diagnosed as having any immunodeficiency, systemic disease, ARC, HIV+, or aids?
❑ ❑ Is there a history of diabetes in your family?
❑ ❑ Are you required, due to health , to restrict your work or activity in anyway?
❑ ❑ Are you on a special or restricted diet of any kind? ❑ No ❑ Yes _____
❑ ❑ Do you use any kind of tobacco? If so, how much: _____ per day, week, month
❑ ❑ Do you use any kind of alcohol? If so, how much: _____ per day, week, month
❑ ❑ Do you have any history of substance abuse or do you currently use recreational drugs?

For women, check all that apply: ❑ Pregnant ❑ Nursing ❑ Taking Birth control Pills

Check all of the following that you may have had in the past or that currently apply to you:

❑ Chest Pain upon Exertion
❑ Shortness of Breath
❑ High Blood Pressure
❑ Low Blood Pressure
❑ Heart Valve Prosthesis
❑ Mitral Valve Prolapse
❑ Congenital Heart Lesion
❑ Diabetes
❑ Rheumatic Fever
❑ Heart Murmur
❑ Damaged Heart Valve
❑ Heart Arrthymla
❑ Tachycardia
❑ Heart Surgery

❑ Cardiac Pacemaker
❑ Stroke
❑ Recurrent Infections
❑ Impaired Liver Function
❑ Kidney Disease
❑ Impaired Kidney Function
❑ Joint Replacement Surgery
❑ Hiatal Hernia
❑ Esophygeal Reflux
❑ Osteoporosis
❑ Anorexia or Bulemia
❑ Irritable Bowel Syndrome
❑ Colitis
❑ G.I. Ulcers

❑ Crohn's Disease
❑ Radiation Therapy
❑ Chemotherapy
❑ Cancer
❑ Sleep Apnea
❑ Asthma
❑ Bronchitis
❑ Emphysema
❑ Sinus Problems
❑ Persistent Cough
❑ Tuberculosis
❑ Recent Weight Loss
❑ Connective Tissue Disorder

❑ Chronic Fatigue
❑ Rheumatoid Arthritis
❑ Headaches or Migraines
❑ Mental Health Problems
❑ Neurological Disorders
❑ Epilepsy
❑ Seizures
❑ Hepatitis – Type A B C
❑ Wear Contact Lenses
❑ Glaucoma
❑ Cataracts
❑ Severely Impaired Vision

❑ Received Blood Transfusion (Dates: _____)

Do you have any disease, probelm or condition not listed above? Please explain: _____

_____

CONT'D NEXT PAGE

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PATIENT NAME: _____

RESPONSIBLE PARTY INFORMATION

Name: _____
Last *First* *Middle Initial*

Residence: _____
Street *City* *State* *Zip*

Mailing Address: _____

How long at this address? _____ Rent or Own? _____ Monthly Rent or Mortgage: _____

Previous Address: _____
If less than 3 yrs. *Street* *City* *State* *Zip*

Social Security #: _____ Birthdate: _____ Relationship to Patient: _____

Employer: _____ Occupation: _____ No. Years Employed: _____

Home Phone: _____ Work Phone: _____

Spouse Name: _____

Spouse Employer: _____ Occupation: _____ No. Years Employed: _____

INSURANCE INFORMATION

Insured's Name: _____ Insured's Social Sec. # _____

Insurance Company: _____ Group# _____ ID# _____

Insurance Co. Address: _____ Insured's D.O.B. _____
Street

_____
City *State* *Zip*

Do you have dual coverage? ❑ YES ❑ NO If Yes, Please fill out the following:

Insured's Name: _____ Insured's Social Sec. # _____

Insurance Company: _____ Group# _____ ID# _____

Insurance Co. Address: _____ Insured's D.O.B. _____
Street

_____
City *State* *Zip*

Insured's Employer: _____

I understand that, where appropriate, credit Bureau reports may Be obtained

Signature of Patient or legal guardian: *Date:* *Reviewed By:*