Monica Boehmer, DDS, PC 3309 Juan Tabo NE, Suite A, Albuquerque, NM 87111 (505)271-8009 www.boehmerdds.com
Fellow Academy of General Dentistry

Personal Information

Name:_____ Preferred Name:_____ Sex (M) (F)

SSN:_____ Date of Birth:_____ Marital Status Other

Address:_____Zip:_____ Home Phone:(___)_____

Employer:_____ Work Phone:(___)_____

Occupation:_____ Cell Phone:(___)_____

Employer's Address:_____

E-mail:_____

Responsible Party Information

Same as Above ◯ ◯

Responsible Party:_____ Date of Birth:_____ Marital Status Other

Relationship to patient:_____ SSN:_____ Driver's Lic. #:_____

Address:_____ Zip:_____ Home Phone:(___)_____

Employer:_____ Work Phone:(___)_____

Address:_____

Dental insurance - Primary Insurance

Do you have insurance? ◯ ◯

Employer:_____ Insurance Co:_____

Name of insured:_____ SSN:_____ DOB:_____

Relationship to Patient:_____

Group number:_____ Member ID number:_____

Claims mailing address:_____ 800 number:_____

Dental insurance - Secondary insurance

Do you have secondary insurance? ◯ ◯

Employer:_____ Insurance Co:_____

Name of insured:_____ SSN:_____ DOB:_____

Relationship to Patient:_____

Group number:_____ Member ID number:_____

Claims mailing address:_____ 800 number:_____

Former Dentist (if requesting X-rays):_____

In case of Emergency whom may we call?_____ Phone:_____

Who may we thank for referring you?:_____

Monica Boehmer, DDS, PC 3309 Juan Tabo NE, Suite A, Albuquerque, NM 87111 (505)271-8009 www.boehmerdds.com
Fellow Academy of General Dentistry

Medical History

Patient Name:_____

Your answers are for our records only and will be considered confidential.

Has there been any change in your general health, or surgeries within the past year? YES NO

_____

Please check the box if you have had any of the following:

- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Valve
- ☐ High Blood Pressure
- ☐ Pacemaker
- ☐ Stroke
- ☐ Heart Attack
- ☐ Coronary Occlusion
- ☐ Arteriosclerosis
- ☐ Rheumatic Fever
- ☐ Coumadin/blood thinner
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Radiation Treatment
- ☐ Tumors
- ☐ Hepatitis
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Tuberculosis
- ☐ Thyroid problems
- ☐ Tobacco user

  Type?_____ packs per day_____

- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Osteoporosis
- ☐ Rheumatoid arthritis
- ☐ Dizziness
- ☐ Epilepsy/seizures
- ☐ Head Injuries
- ☐ Psychiatric Treatment
- ☐ Eating Disorders
- ☐ Sinus Problems
- ☐ Asthma
- ☐ Emphysema
- ☐ Hay Fever
- ☐ Stomach Problems
- ☐ Ulcers
- ☐ Glaucoma
- ☐ Snoring
- ☐ Sleep Apnea
- ☐ Contact lenses
- ☐ Currently pregnant or nursing

- ☐ Anemia
- ☐ Blood Disease
- ☐ Diabetes
- ☐ Excessive Bleeding
- ☐ HIV/AIDS
- ☐ Herpes/cold sores

Allergies

- ☐ Penicillin
- ☐ Codeine or other narcotics
- ☐ Aspirin
- ☐ Erythromycin
- ☐ Latex
- ☐ Sedatives
- ☐ Sulfa
- ☐ Local Anesthetics
- ☐ Metals
- ☐ Other drug_____

Other condition not listed above that we should know about

If so, what?_____

Current medications (including non perscription drugs,or birth control pills)

If so, what?_____

Dental History

Please check the box if you have any of the following:

- ☐ bleeding gums
- ☐ sensitivity or pain
  - ☐ hot
  - ☐ cold
  - ☐ sweets
  - ☐ pressure
- ☐ clench your teeth at night
- ☐ grind your teeth at night
- ☐ headaches, #/wk_____
- ☐ neck pain
- ☐ shoulder pain
- ☐ sore facial muscles
- ☐ clicking in your jaw
- ☐ pain in your jaw joint
- ☐ pain in your ear
- ☐ Tinnitis/ringing in your ear

Do you use any of the following?:

- ☐ Pre-Med for Dental Care
- ☐ fear of dental care
- ☐ Nitrous Oxide for Dental Care
- ☐ manual toothbrush
- ☐ electric toothbrush
- ☐ floss/floss aids
- ☐ water pik
- ☐ air flosser
- ☐ nightguard
- ☐ TMJ splint
- ☐ C-PAP
- ☐ Retainer(s)
- ☐ removable dental appliance

- ☐ I am happy with my smile

I wish:

- ☐ for whiter teeth
- ☐ for a bigger smile
- ☐ for bigger teeth
- ☐ for smaller teeth
- ☐ for straighter teeth
- ☐ less gums to show
- ☐ less space between my teeth
- ☐ Other_____

_____

_____ _____

Signature (Patient or Guardian) Date