

Welcome! The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

Today's Date: _____

ABOUT YOU

Name: _____ Male Female
E-mail Address: _____ I prefer to be called: _____
Birthdate: ____ / ____ / ____ Age: ____ SS #: _____ DL#: _____
Home Address: _____

Single Married Divorced Widowed Separated
Home phone: _____ Cell Phone: _____
Employer: _____ Work phone: _____
Employer Address: _____ Occupation: _____ How long employed there? _____
Where & when are best times to reach you? _____
Whom may we thank for referring you? _____
Other family members seen by us: _____
Previous/Past Dentist: _____ Last Visit Date: _____

SPOUSE INFORMATION

Name: _____ DL #: _____
Birthdate: ____ / ____ / ____ Age: ____ SS #: _____
Employer: _____ Work phone: _____

INSURANCE COVERAGE

Primary

Insurance Co. Name: _____ Insurance Co. Address: _____
Insurance Co. Phone #: _____ Group # (Plan, Local or Policy#): _____
Insured's Name: _____ Relation: _____
Insured's Birthdate: ____ / ____ / ____ Insured's SS#: _____
Insured's Employer: _____ Employer's Address: _____

Secondary

Insurance Co. Name: _____ Insurance Co. Address: _____
Insurance Co. Phone #: _____ Group # (Plan, Local or Policy#): _____
Insured's Name: _____ Relation: _____
Insured's Birthdate: ____ / ____ / ____ Insured's SS#: _____
Insured's Employer: _____ Employer's Address: _____

Person Responsible for Account

Name: _____ Relation: _____
Work phone: _____ Home phone: _____
Billing Address: _____
SS#: _____ DL#: _____
Employer: _____

In the event of an emergency, is there someone who lives near you that we should contact?

Name: _____ Relation: _____
Work Phone: _____ Home Phone: _____

MEDICAL HISTORY

Do you have a personal physician? Yes No

Physician's Name: _____

Phone #: _____ Date of last visit: _____

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? Yes No

If yes, please explain: _____

Are you taking any prescription or over-the-counter drugs? Yes No

Please list each one: _____

Do you smoke or use tobacco in any form? Yes No

Have you ever taken Phen-Fen? (also known as Redux or Pandimin)..... Yes No

If so, when? _____

WOMEN: Are you taking birth control pills? Yes No

Are you pregnant? Yes No

How far along? _____

Are you nursing?..... Yes No

DENTAL HISTORY

Why have you come to the dentist today? _____

Do you require antibiotics before dental treatment? Yes No

Are you currently in pain? Yes No

Have you ever had a serious/difficult problem associated with any previous dental work?..... Yes No

Do you now or have you ever experienced pain or discomfort in your jaw joint? (TMJ or TMD)..... Yes No

Your current dental health is: Good Fair Poor

Do you like your smile? Yes No

Do your gums ever bleed?..... Yes No

Have you ever had periodontal disease?..... Yes No

How many times a week do you floss? _____

How many times a day do you brush? _____

Type of bristles Soft Medium Hard

Have you ever had any of the following diseases or medical problems?

- Y N Anemia/Radiation Treatment
- Y N Arthritis
- Y N Artificial Bones/Joints/Valves
- Y N Asthma
- Y N Blood Transfusion
- Y N Cancer/Chemotherapy
- Y N Congenital Heart Defect
- Y N Diabetes
- Y N Difficulty Breathing
- Y N Drug/Alcohol Abuse
- Y N Emphysema/Glaucoma
- Y N Epilepsy/Seizures/Fainting Spells
- Y N Fever Blisters/Herpes
- Y N Heart Attack/Stroke
- Y N Heart Murmur
- Y N Heart Surgery/Pacemaker
- Y N Hemophilia/Abnormal Bleeding
- Y N Hepatitis
- Y N High/Low Blood Pressure
- Y N HIV+ / AIDS
- Y N Kidney Problems
- Y N Mitral Valve Prolapse
- Y N Psychiatric Problems
- Y N Severe/Frequent Headaches
- Y N Shingles
- Y N Sickle Cell Disease/Traits
- Y N Sinus Problems
- Y N Tuberculosis (TB)
- Y N Ulcers/Colitis
- Y N Venereal Disease

Please list any serious medical condition(s) that you have ever had: _____

Are you allergic to any of the following?

- Y N Aspirin
- Y N Codeine
- Y N Dental Anesthetics
- Y N Erythromycin
- Y N Jewelry/Metals
- Y N Latex
- Y N Penicillin
- Y N Tetracycline
- Y N Other

Please list any other drugs/materials that you are allergic to: _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles my insurance does not cover.

Signature _____

Date _____

Payment is due in full at time of treatment unless prior arrangements have been approved.

OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient. Initials: _____ Date: _____

Doctor's comments: _____

Medical History Updates:

Date: _____ Comments: _____ Signature: _____

Date: _____ Comments: _____ Signature: _____

Date: _____ Comments: _____ Signature: _____