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
LAST FIRST MI

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 #: _____
LAST FIRST MI

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

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:

_____

_____

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

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: _____