

Welcome

Please take a few minutes to fill out this form. Please fill it out as completely as possible.
The more we know about you, the better we can care for you.

① About You

Today's Date _____

Name: _____
LAST FIRST MI

I prefer to be called: _____ Male Female

Birthdate: ___ / ___ / ___ Age: _____ SS#: _____

Home Address: _____
APT / CONDO # _____

CITY STATE ZIP

Single Married Divorced Widowed Separated

Home #: _____ Pager/Other: _____

Work #: _____ Ext: _____ DL#: _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where & when are the best times to reach you? _____

Who may we thank for referring you? _____

Other Family members seen by us: _____

Previous / present Dentist: _____
(PLEASE CIRCLE)

Last visit date: _____

② Spouse Information

Their Name: _____

Employer: _____

Work #: _____ Ext: _____ SS#: _____

Birthdate: ___ / ___ / ___ DL#: _____

Person Responsible for Account: _____

Work #: _____ Ext: _____ Home #: _____

Billing Address: _____

Relationship: _____ SS#: _____ ZIP _____

Employer: _____ DL#: _____

③ Dental Insurance

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy): _____

Insured's Name: _____ Relation: _____

Insured's Birthday: ___ / ___ / ___ Insured's SS#: _____

Insured's Employer: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy): _____

Insured's Name: _____

Insured's Birthday: ___ / ___ / ___ Insured's SS#: _____

Insured's Employer: _____

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

Their name: _____ Relation _____

Work #: _____ Home #: _____

④ Medical History

Do you have a personal physician? Yes No

Physician's Name: _____

Phone #: _____ Date of last visit: _____

Continued on back . . .

④ Medical History cont.

Your current physical health is:

Good Fair Poor

Are you currently under the care of a physician?

Yes No

Please explain _____

Are you taking any prescription / over the counter drugs?

Yes No

Please list each one _____

For Women

Are you taking birth control pills? Yes No

Are you pregnant? Yes Week # _____ No

Are you nursing? Yes No

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

(PLEASE CIRCLE Y OR N)

- | | |
|---|--|
| Y <input type="checkbox"/> N <input type="checkbox"/> Heart Attack/Stroke | Y <input type="checkbox"/> N <input type="checkbox"/> Psychiatric Problem |
| Y <input type="checkbox"/> N <input type="checkbox"/> Cancer/Chemotherapy | Y <input type="checkbox"/> N <input type="checkbox"/> Epilepsy/Seizures |
| Y <input type="checkbox"/> N <input type="checkbox"/> Heart Murmur | Y <input type="checkbox"/> N <input type="checkbox"/> Diabetes/TB |
| Y <input type="checkbox"/> N <input type="checkbox"/> Rheumatic Fever | Y <input type="checkbox"/> N <input type="checkbox"/> Drug/Alcohol Abuse |
| Y <input type="checkbox"/> N <input type="checkbox"/> HIV+/AIDS | Y <input type="checkbox"/> N <input type="checkbox"/> Venereal Disease |
| Y <input type="checkbox"/> N <input type="checkbox"/> Heart Surgery/Pacemaker | Y <input type="checkbox"/> N <input type="checkbox"/> Hemophilia/Bleeding |
| Y <input type="checkbox"/> N <input type="checkbox"/> Shingles | Y <input type="checkbox"/> N <input type="checkbox"/> Ulcers/Colitis |
| Y <input type="checkbox"/> N <input type="checkbox"/> Mitral Valve Prolapse | Y <input type="checkbox"/> N <input type="checkbox"/> Congenital Heart ds. |
| Y <input type="checkbox"/> N <input type="checkbox"/> Kidney Problems | Y <input type="checkbox"/> N <input type="checkbox"/> Anemia/Radiation tr. |
| Y <input type="checkbox"/> N <input type="checkbox"/> Artificial Bones/Joints | Y <input type="checkbox"/> N <input type="checkbox"/> Asthma/Arthritis |
| Y <input type="checkbox"/> N <input type="checkbox"/> Artificial Valves | Y <input type="checkbox"/> N <input type="checkbox"/> Difficulty Breathing |
| Y <input type="checkbox"/> N <input type="checkbox"/> Sinus Problems | Y <input type="checkbox"/> N <input type="checkbox"/> Hospitalized in past |
| Y <input type="checkbox"/> N <input type="checkbox"/> High/Low Blood Pressure | Y <input type="checkbox"/> N <input type="checkbox"/> Hepatitis |
| Y <input type="checkbox"/> N <input type="checkbox"/> Fever Blisters | Y <input type="checkbox"/> N <input type="checkbox"/> Blood Transfusion |
| Y <input type="checkbox"/> N <input type="checkbox"/> Severe/Frequent Headaches | Y <input type="checkbox"/> N <input type="checkbox"/> Emphysema |

Please list any serious medical conditions that you have ever had:

Are you allergic to any of the following drugs?

- | | | |
|--|--|---|
| Y <input type="checkbox"/> N <input type="checkbox"/> Penicillin | Y <input type="checkbox"/> N <input type="checkbox"/> Tetracycline | Y <input type="checkbox"/> N <input type="checkbox"/> Latex |
| Y <input type="checkbox"/> N <input type="checkbox"/> Aspirin | Y <input type="checkbox"/> N <input type="checkbox"/> Codeine | Y <input type="checkbox"/> N <input type="checkbox"/> Other |
| Y <input type="checkbox"/> N <input type="checkbox"/> Erythromycin | Y <input type="checkbox"/> N <input type="checkbox"/> Dental Anesthetics | |

Please list any other drugs that you are allergic to:

⑤ Dental History

Why have you come to the dentist today? _____

Are you currently in pain? Yes No

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

If so, please explain _____

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

Have you ever had a local anesthetic (Novocaine)? Yes No

Do your gums bleed? Yes No

Is any part of your mouth sensitive to cold or other irritants? Yes No

How many times a week do you floss? _____

How many times a day do you brush? _____

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 the 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 with my informed consent that I may need during diagnosis and treatment.

SIGNATURE _____

DATE _____

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

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help.

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

.... OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein. _____

INITIALS

Doctor's Comments: _____

MEDICAL HISTORY UPDATE

- | | | |
|---------------|----------------|-----------------|
| 1. Date _____ | Comments _____ | Signature _____ |
| 2. Date _____ | Comments _____ | Signature _____ |
| 3. Date _____ | Comments _____ | Signature _____ |