

Welcome

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

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ABOUT YOU

Today's Date: _____

E-mail Address: _____

Name: _____
Last First Mi Mr Mrs Ms Dr

I prefer to be called: _____ Male Female

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

Home Address: _____
Apt/Condo #

_____ City State Zip

Single Married Partnered Divorced/Separated Widowed

Hm #: (____) _____ Cell / Other #: _____

Wk #: (____) _____ Ext: _____ DL #: _____

Employer: _____

Employer's Address: _____

_____ City State Zip

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we Thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____
(Please Circle)

Person Responsible for Account: _____

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SPOUSE INFORMATION

His / Her Name: _____

Employer: _____

Wk #: (____) _____ Ext: _____ SS #: _____

Birthdate: ___/___/___ DL #: _____

Relative or Friend not living with you.

His / Her Name: _____ Relation: _____

Wk #: (____) _____ Hm #: (____) _____

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INSURANCE

Primary Insurance

Dental Coverage? Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

_____ City State Zip

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

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

Insured's Employer: _____

Employer's Address: _____

_____ City State Zip

Secondary Insurance

Dental Coverage? Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

_____ City State Zip

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

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

Insured's Employer: _____

Employer's Address: _____

_____ City State Zip

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

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 that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature _____

Date _____

CONTINUED ON BACK



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

Please explain: _____

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

Have you had any metal rods, pins or implants? Yes No

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

Please list each one: _____

Have you ever taken Phen-Fen? (Also known as Redux or Pondimin) Yes No

If so, when? _____

Have you ever taken Fosamax, or any other bisphosphonate? Yes No

For Women: Are you taking birth control pills? Yes No

Are you pregnant? Yes No Week #: _____

Are you nursing? Yes No

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

- Abnormal Bleeding / Hemophilia
- AIDS
- Alcohol / Drug Abuse
- Anemia
- Arthritis
- Artificial Bones / Joints / Valves
- Asthma
- Blood Transfusion
- Cancer / Chemotherapy
- Collitis
- Congenital Heart Defect
- Diabetes
- Difficulty Breathing
- Emphysema
- Epilepsy
- Fainting Spells
- Frequent Headaches
- Glaucoma
- Hay Fever
- Heart Attack / Heart Surgery
- Heart Murmur
- Hepatitis

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

- Herpes / Fever Blisters
- High Blood Pressure
- HIV +
- Hospitalized for Any Reason
- Kidney Problems
- Liver Disease
- Low Blood Pressure
- Lupus
- Mitral Valve Prolapse
- Pacemaker
- Psychotic Problems
- Radiation Treatment
- Rheumatic / Scarlet Fever
- Seizures
- Shingles
- Sickle Cell Disease / Traits
- Sinus Problems
- Stroke
- Thyroid Problems
- Tuberculosis (TB)
- Ulcers
- Venereal Disease

Are you allergic to any of the following?

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

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

Has there been any change in your health status since your last visit? **Y** **N**

If Yes, please explain: _____

Has there been any change in your health status since your last visit? **Y** **N**

If Yes, please explain: _____

MEDICAL HISTORY UPDATE

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



DENTAL HISTORY

Why have you come to the dentist today? _____

Are you currently in pain? Yes No

Do you require antibiotics before dental treatment? Yes No

Your current dental health is: **Good** **Fair** **Poor**

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

Do you floss daily? **Yes** **No** Brush daily? **Yes** **No**

Type of bristles on your toothbrush? **Hard** **Medium** **Soft**

Have you ever had gum treatment? **Yes** **No**

Do your gums ever bleed? **Yes** **No** Ever lit? **Yes** **No**

Have you ever had periodontal diseases? **Yes** **No**

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

Are your teeth sensitive to heat, cold, or anything else? **Yes** **No**

Do you have any loose teeth? **Yes** **No**

Do you still have wisdom teeth? **Yes** **No**

Would you like fresher breath? **Yes** **No** Whiter teeth? **Yes** **No**

Are you happy with the way your smile looks? **Yes** **No**

If not, what would you change? _____

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

Signature _____

Date _____

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

Doctors Comments: _____

_____ Patient Signature _____ Date _____

_____ Patient Signature _____ Date _____

_____ Patient Signature _____ Date _____

_____ Patient Signature _____ Date _____