# Welcome

## ABOUT YOU

Today's Date: _____ E-mail Address: _____

**Name:** _____ I prefer to be called: _____ ❑ Male ❑ Female
Last First Mi Mr Mrs Ms Dr

Birthdate: ___/___/___ Age: _____ Social Security #: _____ ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

**Home Address:** _____
Street City State Zip

Home Phone #: (  )_____ Cell #: (  ) _____ Work Phone #: (  ) _____ Ext: ____ Driver License #: _____

Where & when are best times to reach you? _____ Whom may we Thank for referring you? _____

Other family members seen by us: _____

**Employer:** _____ How long there? _____ Occupation: _____

Employer's Address: _____
Street/PO Box City State Zip

### Neighbor or Relative not living with you

His / Her Name: _____ Relation: _____ Work Phone #: (_____) _____ Home Phone #: (_____) _____

Address: _____
Street City State Zip

### Person Responsible for Account if other than yourself

Name: _____ Relation: _____ Home Phone #: (_____)_____ Social Security #: _____

Employer: _____ Work Phone #: (_____)_____ Ext: ____ Drivers License #: _____

Billing Address: _____
Street City State Zip

## SPOUSE INFORMATION

His / Her Name: _____ Birthdate: ___/___/___ Social Security #: _____

Employer: _____ Work Phone #: (_____)_____ Ext: _____ Drivers License #: _____

## INSURANCE INFORMATION

**Primary Insurance** Medical Coverage? ❑ Yes ❑ No Dental Coverage? ❑ Yes ❑ No Orthodontic Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____ Phone #: (_____)_____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street/PO Box City State Zip

Insured's Name: _____ Insured's Social Security #: _____ Insured's Birthdate: ___/___/___ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street/PO Box City State Zip

**Secondary Insurance** Medical Coverage? ❑ Yes ❑ No Dental Coverage? ❑ Yes ❑ No Orthodontic Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____ Phone #: (_____)_____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street/PO Box City State Zip

Insured's Name: _____ Insured's Social Security #: _____ Insured's Birthdate: ___/___/___ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street/PO Box City State Zip

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# DENTAL HISTORY

**Why have you come to the dentist today?** _____

_____

Are you currently in pain? ❑ Yes ❑ No

Do you need to be premedicated before dental treatment? ❑ Yes ❑ No

Have you experienced problems associated with any previous dental work? ❑ Yes ❑ No

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

Your current dental health is ❑ Good ❑ Fair ❑ Poor

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

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

How long do you use a toothbrush before replacing it?_____

Do you use anything in addition to your brush and floss? ❑ Yes ❑ No

If yes, what? _____

Do your gums ever bleed? ❑ Yes ❑ No Ever Itch? ❑ Yes ❑ No

Have you ever had periodontal disease? ❑ Yes ❑ No

Do you have mobility in your teeth? ❑ Yes ❑ No

Are your teeth sensitive to heat, cold, or anything else? _____

Do you still have wisdom teeth? ❑ Yes ❑ No

If yes, why? _____

Previous / Present Dentist: _____ Last Visit Date: _____
(Please Circle)

Why did you leave your previous dentist? _____

What did you like most & least about any dentist you have seen? _____

_____

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

If not, what would you change? _____

_____

# MEDICAL HISTORY

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name: _____

Address: _____
Street City State Zip

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: _____

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

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

If so, when _____.

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

**Are you allergic to any of the following?**

| | | |
|---|---|---|
| Y N Aspirin | Y N Erythromycin | Y N Sedatives |
| Y N Barbiturates | Y N Jewelry | Y N Sulfa Drugs |
| Y N Codeine | Y N Latex | Y N Tetracycline |
| Y N Dental Anesthetics | Y N Penicillin | Y N Other |

Please list additional drugs that cause allergic reactions: _____

_____

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

Are you pregnant? ❑ Unsure ❑ Yes ❑ No

Week #: _____ Are you nursing? ❑ Yes ❑ No

**Are you taking any of the following?**

| | | | | |
|---|---|---|---|---|
| Y N Acetaminophen | Y N Aspirin | Y N Cold Remedies | Y N Nitroglycerin | Y N Thyroid Medicine |
| Y N Antibiotics | Y N Blood Thinners | Y N Digitalis/Heart Meds | Y N Recreational Drugs | Y N Tranquilizers |
| Y N Antihistamines | Y N Blood Pressure Meds | Y N Insulin/Diabetes Drugs | Y N Steroids/Cortisone | |

Are you taking any prescription/over-the-counter-drugs not listed above? ❑ Yes ❑ No If yes, please list each one: _____

**Do you or have you experienced the following?**

| | | | | |
|---|---|---|---|---|
| Y N Abnormal Bleeding | Y N Colitis | Y N Headaches | Y N Kidney Problems | Y N Seizures |
| Y N Alcohol Abuse | Y N Congenital Heart Defect | Y N Heart Attack | Y N Liver Disease | Y N Shingles |
| Y N Anemia | Y N Diabetes | Y N Heart Murmur | Y N Low Blood Pressure | Y N Sickle Cell Disease |
| Y N Arthritis | Y N Difficulty Breathing | Y N Heart Surgery | Y N Lupus | Y N Sinus Problems |
| Y N Artificial Bones/Joints | Y N Drug Abuse | Y N Hemophilia | Y N Mitral Valve Prolapse | Y N Stroke |
| Y N Artificial Valves | Y N Emphysema | Y N Hepatitis | Y N Pacemaker | Y N Thyroid Problems |
| Y N Asthma | Y N Epilepsy | Y N Herpes | Y N Persistent Cough | Y N Tonsillitis |
| Y N Blood Transfusion | Y N Fainting Spells | Y N High Blood Pressure | Y N Psychiatric Problems | Y N Tuberculosis (TB) |
| Y N Cancer | Y N Fever Blisters | Y N HIV$^+$/AIDS | Y N Radiation Treatment | Y N Ulcers |
| Y N Chemotherapy | Y N Glaucoma | Y N Hospitalized for Any Reason | Y N Rheumatic Fever | Y N Venereal Disease |
| Y N Chicken Pox | Y N Hay Fever | | Y N Scarlet Fever | |

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

# AUTHORIZATIONS

I affirm that the information I have given is correct to the best of my knowledge. It 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 the necessary dental services I may need. **My method of payment** will be (cash, check, Visa, Master Card, Amex). Card # _____ Exp. date _____
(Circle one)

_____
Signature Date

**PAYMENT IS DUE AT TIME OF SERVICE**