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.

1 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 #: ________________

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:________________

2 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 ID #:________________

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 ID #: ________________

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

3 SPOUSE INFORMATION

His / Her Name:____

Employer:____

Wk #: (_____)______________ Ext:______ SS #:________________

Birthdate:____/____/____ DL #: ________________

Relative or Friend not living with you (for emergency).

His / Her Name:________________ Relation: ________________

Wk #: (_____)________________ Hm #: (_____) ________________

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CONTINUED ON BACK

4 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 using a prescribed method of birth control? ☐ 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

Y	N	Abnormal Bleeding / Hemophilia	Y	N	Herpes / Fever Blisters
Y	N	AIDS	Y	N	High Blood Pressure
Y	N	Alcohol / Drug Abuse	Y	N	HIV +
Y	N	Anemia	Y	N	Hospitalized for Any Reason
Y	N	Arthritis	Y	N	Kidney Problems
Y	N	Artificial Bones / Joints / Valves	Y	N	Liver Disease
Y	N	Asthma	Y	N	Low Blood Pressure
Y	N	Blood Transfusion	Y	N	Lupus
Y	N	Cancer / Chemotherapy	Y	N	Mitral Valve Prolapse
Y	N	Colitis	Y	N	Pacemaker
Y	N	Congenital Heart Defect	Y	N	Psychiatric Problems
Y	N	Diabetes	Y	N	Radiation Treatment
Y	N	Difficulty Breathing	Y	N	Rheumatic / Scarlet Fever
Y	N	Emphysema	Y	N	Seizures
Y	N	Epilepsy	Y	N	Shingles
Y	N	Fainting Spells	Y	N	Sickle Cell Disease / Traits
Y	N	Frequent Headaches	Y	N	Sinus Problems
Y	N	Glaucoma	Y	N	Stroke
Y	N	Hay Fever	Y	N	Thyroid Problems
Y	N	Heart Attack / Heart Surgery	Y	N	Tuberculosis (TB)
Y	N	Heart Murmur	Y	N	Ulcers
Y	N	Hepatitis	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	Erythromycin	Y	N	Penicillin
Y	N	Codeine	Y	N	Jewelry/Metals	Y	N	Tetracycline
Y	N	Dental Anesthetics	Y	N	Latex	Y	N	Other

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

5 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 Itch? ☐ Yes ☐ No
Have you ever had periodontal disease? ☐ 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? __________
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

OFFICE USE ONLY OFFICE USE ONLY

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

Initials: ________________ Date: ________________

Doctor's Comments: ______________________
____
____
____
____

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.

MEDICAL HISTORY UPDATE

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. ______________________

____
Patient Signature Date
____
Dentist Signature Date
____
Patient Signature Date
____
Dentist Signature Date

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