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.

1 About You

Today's Date: ________________

E-mail Address: ________________

Name: ________________

I prefer to be called: ________________ ❑ Male ❑ Female

Birthdate: __/__/__ Age: _____ SS #: ________________

Home Address: ________________

____

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Hm #: (____)____________ Pager / Cell #: ____________

Wk #: (____)____________ Ext: ___ DL #: ____________

Employer: ________________

Employer's Address: ________________

How long there? ________ Occupation: ________________

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

Whom may we Thank for referring you? ________________

Other family members seen by us: ________________

Previous / Present Dentist: ________________

Last Visit Date: ________________

2 Spouse Information

His / Her Name: ________________

Employer: ________________

Wk #: (____)____________ Ext: ___ SS #: ____________

Birthdate: __/__/__ DL #: ________________

Person Responsible for Account: ________________

Wk #: (____)____________ Ext: ___ Hm #: (____) ________

Billing Address: ________________

Relation: ________________ SS #: ________________

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 Birthdate: __/__/__ Insured's ID #: ____________

Insured's Employer: ________________

Secondary Dental Insurance

Insurance Co. Name: ________________

Insurance Co. Address: ________________

Insurance Co. Phone #: (____) ________________

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

Insured's Name: ________________ Relation: ____________

Insured's Birthdate: __/__/__ Insured's ID #: ____________

Insured's Employer: ________________

4 Medical History

Do you have a personal physician? ❑ **Yes** ❑ **No**

Physician's Name: ________________

Phone #: (____)____________ **Last Visit Date:**________

Are you currently under the care of a physician? ❑ Yes ❑ No

Please Explain: ________________

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

His / Her Name: ________________ Relation:____________

Wk #: (____)____________ Hm #:(____)____________

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5 Medical History
continued

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

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

Are you taking any prescription/over-the-counter or herbal supplement drugs? ❑ Yes ❑ No

Please list each one: ______________________

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

Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath? ❑ 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
Y N Alcohol / Drug Abuse
Y N Anemia
Y N Arthritis
Y N Artificial Bones / Joints /Valves
Y N Asthma
Y N Blood Transfusion
Y N Cancer / Chemotherapy
Y N Colitis
Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Emphysema
Y N Epilepsy
Y N Fainting Spells
Y N Frequent Headaches
Y N Glaucoma
Y N Hay Fever
Y N Heart Attack
Y N Heart Murmur
Y N Heart Surgery
Y N Hemophilia
Y N Hepatitis
Y N Herpes / Fever Blisters
Y N High Blood Pressure
Y N HIV+ / AIDS
Y N Hospitalized for Any Reason
Y N Kidney Problems
Y N Liver Disease
Y N Low Blood Pressure
Y N Lupus
Y N Mitral Valve Prolapse
Y N Pacemaker
Y N Psychiatric Treatment
Y N Radiation Treatment
Y N Rheumatic /Scarlet Fever
Y N Seizures
Y N Shingles
Y N Sickle Cell Disease
Y N Sinus Problems
Y N Stroke
Y N Thyroid Problems
Y N Tuberculosis (TB)
Y N Ulcers
Y N Venereal Disease

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

____

____

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:

____

____

6 Dental History

Why have you come to the dentist today?

____

____

Has your doctor told you that 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 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 like your smile? ❑ Yes ❑ No

Do your gums ever bleed? ❑ Yes ❑ No

How many times a week do you floss? _______

How many times a day do you brush? _______

Type of bristles? ❑ Hard ❑ Medium ❑ Soft

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 of 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

Payment is due in full at 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 a question at any time, please ask us. We are happy to help.

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

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I verbally reviewed the medical / dental information above with the patient named herein. Initials: ____________ **Date:** __________

Doctor's comments: ______________________

____

MEDICAL HISTORY UPDATE

1. Date: __________ **Comments:** ______________ **Signature:** ____________

2. Date: __________ **Comments:** ______________ **Signature:** ____________

3. Date: __________ **Comments:** ______________ **Signature:** ____________

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