

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. ☺

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/Other#: (____) _____ Work Phone #: (____) _____ Ext: _____ Driver's 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

Spouse Information

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

Employer: _____ Work Phone #: (____) _____ Ext: _____ Driver's License #: _____

Insurance Information

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

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
- Do you floss daily? Yes No Brush daily? Yes No
- Type of bristles on your toothbrush? Hard Medium Soft
- Do your gums ever bleed? Yes No Ever Itch? Yes No
- Have you ever had periodontal disease? Yes No

- Are your teeth sensitive to heat, cold, or anything else? _____
- Do you have mobility in your teeth? Yes No
- Do you still have wisdom teeth? Yes No
- Previous / Present Dentist: _____ Last Visit Date: _____
(Please Circle)
- 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? _____

Medical History

- Do you have a personal physician? Yes No
- Physician's Name: _____
- Address: _____
Street
- City _____ State _____ Zip _____
- Phone #: (____) _____ Date of last visit: _____

- 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 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 taking birth control pills? Yes No
- Are you pregnant? Unsure Yes No
- Week #: _____ Are you nursing? Yes No

Your current physical health is: Good Fair Poor

Do you or have you experienced the following?

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

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

Are you taking any prescription/over the counter drugs? Yes No If yes, please list each one: _____

Are you allergic to any of the following?

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

Please list anything additional that causes allergic reactions: _____

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.

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need. I assign the Doctor all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover. I have received a copy of this offices Notice of Privacy Practices.

Signature Date

Medical History Update

I have read my medical history dated _____ and confirmed that it states past and present medical condition

Signature Date

I have read my medical history dated _____ and confirmed that it states past and present medical condition

Signature Date