

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: _____
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 Divorced Widowed Separated

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

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

Employer: _____

Employer's Address: _____

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)

Last Visit Date: _____

INSURANCE COVERAGE

Primary

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

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

Insured's Name: _____ Relation: _____

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

Insured's Employer: _____

Secondary

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

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

Insured's Name: _____ Relation: _____

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

Insured's Employer: _____

SPOUSE INFORMATION

His / Her Name: _____

Employer: _____

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

Birthdate: ___ / ___ / ___ Driver's License #: _____

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

His / Her Name: _____ Relation: _____

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

Person Responsible for Account: _____

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

Billing Address: _____

Relation: _____ SS #: _____

Employer: _____ DL #: _____

MEDICAL HISTORY

Do you have a personal physician? Yes No

Physician's Name: _____

Phone #: (____) _____ Date of last visit: _____

CONTINUED ON BACK

MEDICAL HISTORY CONTINUED

Your current physical health is: Good Fair Poor
 Are you currently under the care of a physician? Yes No
 Please explain: _____
 Are you taking any prescription / over-the-counter drugs? Yes No
 Please list each one: _____
 Do you smoke or use tobacco in any other form? Yes No
 Have you ever taken Phen-Fen? (Also known as Redux or Pondimin) 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?

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

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

DENTAL HISTORY

Why have you come to the dentist today?

Do 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 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 like your smile? Yes No
 Would you like whiter teeth? Yes No Fresher breath? Yes No
 Do your gums ever bleed? Yes No
 How many times a week do you floss? _____ a day do you brush? _____
 Type of bristles? Soft Medium Hard

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 _____

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.

Signature _____

Date _____

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

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

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: _____