

# 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: \_\_\_\_\_  
LAST FIRST MI MR MRS MS DR

I prefer to be called: \_\_\_\_\_  Male  Female

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ SS #: \_\_\_\_\_

Home Address: \_\_\_\_\_

CITY STATE ZIP

Single  Married  Divorced  Widowed  Separated

Hm #: (\_\_\_\_) \_\_\_\_\_ Pager / Cell #: \_\_\_\_\_

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: \_\_\_\_\_

## 2

### SPOUSE INFORMATION

His / Her Name: \_\_\_\_\_

Employer: \_\_\_\_\_

Wk #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_ SS #: \_\_\_\_\_

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Driver's License #: \_\_\_\_\_

Person Responsible for Account: \_\_\_\_\_

Wk #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_ Hm #: (\_\_\_\_) \_\_\_\_\_

Billing Address: \_\_\_\_\_

Relation: \_\_\_\_\_ SS #: \_\_\_\_\_

Employer: \_\_\_\_\_ DL #: \_\_\_\_\_

## 3

### INSURANCE COVERAGE

#### Primary

Dental Coverage:  Yes  No

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 Coverage:  Yes  No

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: \_\_\_\_\_

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

His / Her Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Wk #: (\_\_\_\_) \_\_\_\_\_ Hm #: (\_\_\_\_) \_\_\_\_\_

## 4

### MEDICAL HISTORY

Do you have a personal physician?  Yes  No

Physician's Name: \_\_\_\_\_

Phone #: (\_\_\_\_) \_\_\_\_\_ Date of last visit: \_\_\_\_\_

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

Please explain: \_\_\_\_\_

CONTINUED ON BACK



# 4

## MEDICAL HISTORY *continued*

Your current physical health is:  Good  Fair  Poor

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 ever taken Phen-fen?  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?

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

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

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

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Aspirin            | <input type="checkbox"/> Y <input type="checkbox"/> N Erythromycin | <input type="checkbox"/> Y <input type="checkbox"/> N Metals       |
| <input type="checkbox"/> Y <input type="checkbox"/> N Codeine            | <input type="checkbox"/> Y <input type="checkbox"/> N Jewelry      | <input type="checkbox"/> Y <input type="checkbox"/> N Penicillin   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Dental Anesthetics | <input type="checkbox"/> Y <input type="checkbox"/> N Latex        | <input type="checkbox"/> Y <input type="checkbox"/> N Tetracycline |

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

# 5

## 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 Do your gums ever bleed?  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

How many times a week do you floss? \_\_\_\_\_ a day do you brush? \_\_\_\_\_

Type of bristles?  Soft  Medium  Hard

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



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 HIPAA Compliant and 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: \_\_\_\_\_