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 these forms completely. The better we communicate, the better we can care for you.

1 ABOUT YOU

Today's Date: _____

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

Home #: _____ Pager / Other #: _____

WK #: _____ Ext _____ DL #: _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Who may we Thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____
(Please Circle)

Last Visit Date: _____

2 SPOUSE INFORMATION

Their Name: _____

Employer: _____

WK #: _____ Ext _____ SS #: _____

Birthdate: _____ DL #: _____

Person Responsible for Account: _____

WK #: _____ Ext _____ HM #: _____

Billing Address: _____
Zip

Relationship: _____ 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 Birthday: ___/___/___ Insured's SS #: _____

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

Insured's Employer: _____

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

Their Name: _____ Relation: _____

WK #: _____ HM #: _____

4 MEDICAL HISTORY

Do you have a personal physician? ☐ No ☐ Yes

Physician's Name: _____

Phone #: _____ Date of last visit: _____

CONTINUED ON BACK OF FORM

4 MEDICAL HISTORY

Your current physical health is ☐ Good ☐ Fair ☐ Poor

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

Please explain _____

Are you taking any prescription / over-the-counter drugs? ☐ No ☐ Yes

Please list each one _____

For Women Are you taking birth control pills? ☐ No ☐ Yes

Are you pregnant? ☐ No ☐ Yes Week # _____

Are you nursing? ☐ No ☐ Yes

Have you ever had any of the following diseases or medical problems?

Y N Heart Attack / Stroke
Y N Heart Disease
Y N Chest Pains
Y N Cancer / Chemotherapy
Y N Heart Murmur
Y N Rheumatic Fever
Y N HIV+ / AIDS
Y N Heart Surgery / Pacemaker
Y N Scarlet Fever
Y N Nervousness
Y N Thyroid Problems
Y N Shingles
Y N Mitral Valve Prolapse
Y N Kidney Problems
Y N Artificial Bones / Joints
Y N Artificial Valves
Y N Sinus Problems
Y N High / Low Blood Pressure
Y N Fever Blisters
Y N Severe / Frequent Headaches
Y N Psychiatric Problems
Y N Epilepsy / Seizures / Fainting Spells
Y N Diabetes / Tuberculosis (TB) / Hypoglycemia
Y N Drug / Alcohol Abuse
Y N Venereal Disease
Y N Hemophilia / Abnormal Bleeding
Y N Ulcers / Colitis
Y N Congenital Heart Defect
Y N Anemia / Radiation Treatment
Y N Arthritis / Rheumatism
Y N Difficulty Breathing / Respiratory Problems
Y N Hospitalized for Any Reason
Y N Hepatitis
Y N Blood Transfusion
Y N Emphysema / Glaucoma
Y N Asthma
Y N Frequent Neck Pain
Y N Back Problems
Y N Cosmetic Surgery
Y N Leukemia

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

_____

_____

Are you allergic to any of the following drugs?

Y N Penicillin
Y N Aspirin
Y N Erythromycin
Y N Tetracycline
Y N Dental Anesthetics
Y N Codeine
Y N Latex
Y N Sulfa
Y N Other

Please list any other drugs you are allergic to: _____

_____

5 DENTAL HISTORY

Why have you come to the dentist today? _____

_____

_____

Are you currently in pain? ☐ No ☐ Yes

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ No ☐ Yes

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ No ☐ Yes

Your current dental health is ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ No ☐ Yes Do your gums ever bleed? ☐ No ☐ Yes

How many times a week do you floss? _____ a day do you brush? _____

Type of bristles? ☐ Hard ☐ Medium ☐ Soft

I

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 with my informed consent that I may need during diagnosis and treatment.

_____

Signature Date

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

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

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

Signature_____ **Date**_____

MEDICAL HISTORY UPDATE

1. Date_____ **Comments** _____ **Signature** _____

2. Date_____ **Comments** _____ **Signature** _____

3. Date_____ **Comments** _____ **Signature** _____