

# 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: \_\_\_\_\_  
APT / CONDO #

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: \_\_\_/\_\_\_/\_\_\_ 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: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

### 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: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

### 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: \_\_\_\_\_

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

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

Please Explain: \_\_\_\_\_

CONTINUED ON BACK



## MEDICAL HISTORY *continued*

**Your current physical health is:**  Good  Fair  Poor  
 Are you taking any prescription / over-the-counter or supplemental drugs?  
 Yes  No  
 Please list each one: \_\_\_\_\_  
 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 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 disease or medical problems? (Please circle option that applies)

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

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  
 Do your gums ever bleed?  Yes  No  
 Have you ever had periodontal disease?  Yes  No  
 How many times a week do you floss? \_\_\_\_\_ 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 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.



Thank you for filling out this form completely. It will enable us to help you more effectively. If you have questions 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.

**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: _____
1. Date: _____	Comments: _____	Signature: _____
1. Date: _____	Comments: _____	Signature: _____