

Welcome

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain optimal 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 Partnered Divorced/Separated Widowed

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

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

Employer: _____

Employer's Address: _____

City State Zip

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)

Person Responsible for Account: _____

2

SPOUSE INFORMATION

His / Her Name: _____

Employer: _____

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

Birthdate: ____/____/____ DL #: _____

Relative or Friend not living with you (for emergency).

His / Her Name: _____ Relation: _____

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

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INSURANCE

Primary Insurance

Dental Coverage? Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

City State Zip

Insurance Co. Phone #: (____) _____

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

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____/____/____ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

City State Zip

Secondary Insurance

Dental Coverage? Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

City State Zip

Insurance Co. Phone #: (____) _____

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

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____/____/____ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

City State Zip

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. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature _____ Date _____

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MEDICAL HISTORY

Do you have a personal physician? Yes No

Physician's Name: _____

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

Your current physical health is: Good Fair Poor

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 been told that you snore or hold your breath while sleeping or wake up gasping for breath? Yes No

Have you had any metal rods, pins or implants? Yes No

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

Please list each one: _____

Have you ever taken Fosamax, or any other bisphosphonate? 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 / Hemophilia | <input type="checkbox"/> Y <input type="checkbox"/> N | Herpes / Fever Blisters |
| <input type="checkbox"/> Y <input type="checkbox"/> N | AIDS | <input type="checkbox"/> Y <input type="checkbox"/> N | High Blood Pressure |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Alcohol / Drug Abuse | <input type="checkbox"/> Y <input type="checkbox"/> N | HIV |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N | Hospitalized for Any Reason |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Arthritis | <input type="checkbox"/> Y <input type="checkbox"/> N | Kidney Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Artificial Bones / Joints / Valves | <input type="checkbox"/> Y <input type="checkbox"/> N | Liver Disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N | Low Blood Pressure |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Blood Transfusion | <input type="checkbox"/> Y <input type="checkbox"/> N | Lupus |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Cancer / Chemotherapy | <input type="checkbox"/> Y <input type="checkbox"/> N | Mitral Valve Prolapse |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Colitis | <input type="checkbox"/> Y <input type="checkbox"/> N | Pacemaker |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Congenital Heart Defect | <input type="checkbox"/> Y <input type="checkbox"/> N | Psychiatric Treatment |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N | Radiation Treatment |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Difficulty Breathing | <input type="checkbox"/> Y <input type="checkbox"/> N | Rheumatic / Scarlet Fever |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Emphysema | <input type="checkbox"/> Y <input type="checkbox"/> N | Seizures |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N | Shingles |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Fainting Spells | <input type="checkbox"/> Y <input type="checkbox"/> N | Sickle Cell Disease / Traits |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Frequent Headaches | <input type="checkbox"/> Y <input type="checkbox"/> N | Sinus Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Glaucoma | <input type="checkbox"/> Y <input type="checkbox"/> N | Stroke |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Hay Fever | <input type="checkbox"/> Y <input type="checkbox"/> N | Thyroid Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Heart Attack / Surgery | <input type="checkbox"/> Y <input type="checkbox"/> N | Tuberculosis (TB) |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Heart Murmur | <input type="checkbox"/> Y <input type="checkbox"/> N | Ulcers |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Hepatitis | <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 | Penicillin |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Codeine | <input type="checkbox"/> Y <input type="checkbox"/> N | Jewelry/Metals | <input type="checkbox"/> Y <input type="checkbox"/> N | Tetracycline |
| <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 | Other |

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

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.

MEDICAL HISTORY UPDATE

Has there been any change in your health status since your last visit? Y N
If Yes, please explain. _____

Has there been any change in your health status since your last visit? Y N
If Yes, please explain. _____

Patient Signature _____ Date _____

Dentist Signature _____ Date _____

Patient Signature _____ Date _____

Dentist Signature _____ Date _____



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

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

Do you floss daily? Yes No Brush daily? Yes No

Type of bristles on your toothbrush? Hard Medium Soft

Have you ever had gum treatment? Yes No

Do your gums ever bleed? Yes No Ever Itch? Yes No

Have you ever had periodontal disease? Yes No

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

Are your teeth sensitive to heat, cold, or anything else? _____

Do you have any loose teeth? Yes No

Do you still have wisdom teeth? Yes No

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? _____

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 _____

OFFICE USE ONLY OFFICE USE ONLY

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

Initials: _____ Date: _____

Doctor's Comments: _____
