

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

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

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

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

Relation: \_\_\_\_\_

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

## 3

### INSURANCE INFORMATION

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

Do you have secondary Dental Coverage:  Yes  No



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 \_\_\_\_\_

**Payment is due in full at the time of treatment unless prior arrangements have been approved.**

## 4

### PHYSICIAN INFORMATION

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 & DENTAL HISTORY

List any prescriptions/over-the-counter drugs you are taking:

Please list each one: \_\_\_\_\_

\_\_\_\_\_

Have you ever taken Fosamax or any other bisphosphonate?  Y  N

Are you pregnant?  Yes  No Week #: \_\_\_\_\_

Do you have any metal plates, pins, screws or joint replacements?  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 Bone /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 drugs/materials that you are allergic to: \_\_\_\_\_

\_\_\_\_\_

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 / TMDJ)?  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? \_\_\_\_\_

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

Type of bristles?  Soft  Med  Hard

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

Do you snore?  Yes  No

Do you have high blood pressure?  Yes  No

Are you excessively tired during the day?  Yes  No

Have you been told you stop breathing during your sleep?  Yes  No

Do you awaken from sleep gasping for air or choking?  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 \_\_\_\_\_

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

I verbally reviewed the medical / dental information above with the patient named herein. Initials: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor's Comments: \_\_\_\_\_

\_\_\_\_\_