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.

Date: ___/___/___

1 Tell Us About Yourself

E-Mail Address: _____

Name: _____
Last First MI

I prefer to be called: _____ ___ **Male** ___ **Female**

Birthdate: ____/____/____ Age: _____ **SS #:** _____

Home Address:_____

_____
City State Zip

Phone #: _____

Best time to reach you? _____

___ Single ___ Married ___ Separated ___ Divorced ___ Widowed

Employer: _____

Employer Address: _____

How long there? _____ Occupation: _____

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: _____

Home/ Cell #: _____ SS #: _____

Birthdate: ___/___/___ Driver's License #: _____

3 Person Responsible For Account

Name: _____ Relation: _____

Billing Address: _____

_____
City State Zip

Employer: _____ Home/ Cell #:_____

SS#: _____ DL #: _____

Patient Name: _____

4 Primary Insurance

Dental Coverage? ___ Yes ___ No Ortho Coverage? ___ Yes ___ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____ Group/ Policy #: _____

Policy Owner's Name: _____ Relation to Patient: _____

Policy Owner's Birth Date: ___/___/___ ID #: _____

Policy Owner's Employer: _____

Secondary Insurance

Dental Coverage? ___ Yes ___ No Ortho Coverage? ___ Yes ___ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____ Group/ Policy #: _____

Policy Owner's Name: _____ Relation to Patient: _____

Policy Owner's Birth Date: ___/___/___ ID #: _____

Policy Owner's Employer: _____

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

His / Her Name: _____ Relation: _____

Work #: _____ Home #: _____

5 Medical History

Do you have a physician? ___ Yes ___ No

Physician Name: _____ Phone #: _____

Date of Last Visit: ___/___/___

Are you currently under the care of a physician? ___ Yes ___ No Please explain: _____

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

Patient Name: _____

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

(Please circle Yes or No)

Y N Abnormal Bleeding	Y N Alcohol/ Drug Abuse	Y N Anemia
Y N Arthritis	Y N Artificial Bones/ Joints/ Valves	Y N Asthma
Y N Blood Transfusions	Y N Cancer/ Chemotherapy	Y N Colitis
Y N Congenital Heart Defects	Y N Diabetes	Y N Difficulty Breathing
Y N Emphysema	Y N Epilepsy	Y N Fainting Spells
Y N Frequent Headaches	Y N Glaucoma	Y N Hay Fever
Y N Heart Attack	Y N Heart Murmur	Y N Heart Surgery
Y N Hemophilia	Y N Hepatitis	Y N Herpes / Fever Blisters
Y N High Blood Pressure	Y N HIV+ / AIDS	Y N Hospitalized for Any Reason
Y N Kidney Problems	Y N Liver Disease	Y N Low Blood Pressure
Y N Mitral Valve Prolapse	Y N Pacemaker	Y N Psychiatric Problems
Y N Radiation Treatment	Y N Rheumatic Fever / Scarlet Fever	Y N Seizures
Y N Shingles	Y N Sickle Cell Disease/ Traits	Y N Sinus Problems
Y N Stroke	Y N Thyroid Problems	Y N Tuberculosis (TB)
Y N Ulcers	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 other drug/ materials that you are allergic to: _____

_____

7 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

Patient Name: _____

8 I understand that the information that I have given 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

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

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:** _____