

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.

About You

Today's Date _____ E-mail Address _____

Name : _____

I preferred to be called _____

___ Male ___ Female Birthdate: ___/___/___ Age: ___

Social Security # _____

Home Address: _____

___ Single ___ Married ___ Divorced ___ Widowed ___ Separated

Home #: _____ Cell/Mobile #: _____ Work #: _____

Drivers License #: _____

Employer: _____

Employer Address: _____

How long there? _____ Occupation: _____

When & Where are the best times to reach you? _____

Whom may we Thank for referring you? _____

Other family members seen by us: _____

Previous/Present Dentist _____ Last Visit Date: _____

Spouse Information

His/Her Name: _____

Employer: _____

Work #: _____ Ext (_____) Social Security #: _____

Birthdate: ___/___/___ Drivers Licence#: _____

Person Responsible for Account: _____

Wk#: _____ Ext(_____) Home#: _____

Billing

Address: _____

Relation: _____ Social Security #: _____

Employer: _____ Drivers License #: _____

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 I.D. #: _____

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 Birthdate: ____/____/____ Insured's I.D. #: _____

Insured's Employer: _____

Medical History

Do you have a personal physician? Yes _____ No _____

Phone #: _____ Last Visit Date: _____

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

Please explain: _____

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

His/Her Name: _____ Relation: _____

Work #: _____ Home #: _____

Your current physical health is: _____good _____fair _____poor

Do you smoke or use tobacco in any form? _____yes _____no

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

Medical History (continued)

Have you ever taken Phen-fen? _____yes _____no

For Women: Are you using a prescribed method of birth control? _____yes _____no

Are you pregnant? _____no _____yes week # _____

Are you nursing? _____yes _____no

Please circle Yes or No to any of the following conditions you currently have or have had:

- | | | | |
|-----|--------------------------------|-----|-----------------------------|
| Y N | Abnormal Bleeding | Y N | Herpes/Fever Blisters |
| Y N | Alcohol/ Drug Abuse | Y N | High Blood Pressure |
| Y N | Anemia | Y N | HIV+/AIDS |
| Y N | Arthritis | Y N | Hospitalized for Any Reason |
| Y N | Artificial Bones/Joints/Valves | Y N | Kidney Problems |
| Y N | Asthma | Y N | Liver Disease |
| Y N | Blood Transfusion | Y N | Low Blood Pressure |
| Y N | Cancer/ Chemotherapy | Y N | Lupus |
| 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 |
| Y N | Glaucoma | Y N | Sinus Problems |
| Y N | Hay Fever | Y N | Stoke |
| Y N | Heart Attack | Y N | Thyroid Problems |
| Y N | Heart Murmur | Y N | Tuberculosis |
| Y N | Heart Surgery | Y N | Ulcers |
| Y N | Hemophilia | Y N | Venereal Disease |
| Y N | Hepatitis | | |

Please list any medical conditions 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?

Has your doctor told you that 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 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

How many times a week do you floss? _____

How many times 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 of confidence and it is my responsibility to inform the 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

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