# 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:** _____

I prefer to be called: _____ ❑ Male ❑ Female

Birthdate: __/__/__ Age: _____ SS #: _____

Home Address: _____

_____

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

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

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

**Employer:** _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where & when 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: _____

## 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 SS #: _____

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 SS #: _____

Insured's Employer: _____

## 4 Medical History

**Do you have a personal physician?** ❑ **Yes** ❑ **No**

Physician's Name: _____

**Phone #:** (____)_____ **Last Visit Date:** _____

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

His / Her Name: _____ Relation: _____

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

# 5 Medical History
continued

**Your current physical health is:**
❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ Yes ❑ No
Please Explain: _____

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

Please list each one: _____

_____

Have you ever taken Phen-Fen? ❑ Yes ❑ No
(Also known as Redux or Pondimin) If yes, when? _____

**For Women:** Are you taking birth control pills? ❑ 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?**

| | | | | | |
|---|---|---|---|---|---|
| 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 Bones / 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 |
| 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 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:

_____

_____

# 6 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 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 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 a question at any time, please ask us. We are happy to help.**

**Our office is 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:** _____
2. **Date:** _____ **Comments:** _____ **Signature:** _____
3. **Date:** _____ **Comments:** _____ **Signature:** _____