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: _____

Birthdate: ___/___/___ Age: _____ SS #: _____

Home Address: _____

_____
CITY STATE ZIP

❑ Single ❑ Married

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

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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

5 Medical & Dental History

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: _____

_____

_____

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:

_____

_____

_____

_____

_____

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

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

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: _____

_____