

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 _____

Name _____

Birth date _____ SS# _____

Home Address _____

Single Married Divorced Widowed Separated

HM# (____) _____ CELL# (____) _____

WK# (____) _____ EXT _____

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: _____

Dentist Phone # (____) _____ Last visit Date _____

SPOUSE INFORMATION

His/Her Name _____

Employer _____

WK# (____) _____ EXT _____

SS# _____ Birth date _____

PERSON RESPONSIBLE FOR ACCOUNT

NAME _____

HM# (____) _____ WK# (____) _____

SS# _____

RELATIONSHIP _____

INSURANCE

PRIMARY INSURANCE

INSURANCE CO. NAME _____

INSURANCE CO. PHONE # (____) _____

INSURED NAME _____

RELATIONSHIP _____

INSURED BIRTH DATE _____

GROUP/POLICY # _____

INSURED ID# _____

SECONDARY INSURANCE

INSURANCE CO. NAME _____

INSURANCE CO. PHONE # (____) _____

INSURED NAME _____

RELATIONSHIP _____

INSURED BIRTH DATE _____

GROUP/POLICY # _____

INSURED ID# _____

MEDICAL HISTORY

DO YOU HAVE A PERSONAL PHYSICIAN YES NO

PHYSICIAN'S NAME _____

PHONE # (____) _____

DATE OF LAST VISIT _____

ARE CURRENTLY UNDER THE CARE OF A PHYSICIAN YES NO

PLEASE EXPLAIN _____

MEDICAL HISTORY CONTINUED

YOUR CURRENT PHYSICAL HEALTH IS:

GOOD FAIR POOR

DO YOU SMOKE OR USE TOBACCO IN ANY OTHER FORM
 YES NO

HAVE YOU HAD ANY METAL RODS, PINS OR IMPLANTS
 YES NO

ARE YOU TAKING ANY PRESCRIPTION,
OVER-THE-COUNTER OR HERBAL SUPPLEMENT
 YES NO

PLEASE LIST EACH ONE: _____

FOR WOMEN: Are you using a prescribed method of birth control? 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 |
| Y N | Anemia | Y N | High Blood Pressure |
| Y N | Arthritis | Y N | Hospitalized |
| Y N | Artificial Bones | Y N | Kidney Problems |
| Y N | Artificial Joints | Y N | Liver Disease |
| Y N | Artificial Valves | Y N | Low Blood Pressure |
| Y N | Asthma | Y N | Lupus |
| Y N | Blood Transfusion | Y N | Mitral Valve Prolapse |
| Y N | Cancer/Chemotherapy | Y N | Pace Maker |
| Y N | Colitis | Y N | Psychiatric Problems |
| Y N | Congenital Heart Defect | Y N | Radiation Treatment |
| Y N | Diabetes | Y N | Rheumatic Fever |
| Y N | Difficulty Breathing | Y N | Scarlet Fever |
| Y N | Emphysema | Y N | Seizures |
| Y N | Epilepsy | Y N | Shingles |
| Y N | Fainting Spells | Y N | Sickle Cell Disease |
| Y N | Fever Blisters | Y N | Sickle Cell Traits |
| Y N | Frequent Headaches | Y N | Sinus Problems |
| Y N | Glaucoma | Y N | Stroke |
| Y N | Hay Fever | Y N | Thyroid Problems |
| Y N | Heart attach/Surgery | Y N | Tuberculosis TB |
| Y N | Heart Murmur | Y N | Ulcers |
| | | Y N | Venereal Disease |

Anything you would like to discuss with the dentist in private? Y N

List any serious Medical conditions that you have ever had:

Are you allergic to any of the following?

- | | | | |
|-----|-------------------|-----|--------------|
| Y N | Aspirin | Y N | Codeine |
| Y N | Dental Anesthetic | Y N | Erythromycin |

- | | | | |
|-----|----------------|-----|--------------|
| Y N | Jewelry/ Metal | Y N | Latex |
| Y N | Penicillin | Y N | Tetracycline |

Please list any other drugs/materials that you are allergic to: _____

DENTAL HISTORY

WHY HAVE YOU COME TO THE DENTIST TODAY? _____

- Have you ever taken Fosamax, or any other bisphosphonate? Y N
 Have you ever taken Phen-Fen? Y N
 Do you require antibiotics before dental treatment? Y N
 Are you currently in pain? Y N
 Have you ever had a serious / difficult problem associated with any previous dental work? Y N
 Have you ever had gum treatment? Y N

Your current dental health is Good Fair Poor

- Do you like your smile? Y N Do your gums ever bleed? Y N
 How many times a week do you floss? _____ a day you brush? _____
 Type of bristles? Hard Medium Soft
 How long do you use a toothbrush before replacing it? _____
 Are your teeth sensitive to heat, cold, or anything else? _____
 Have you lost any teeth? Y N
 If yes, why? _____

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.

Signature _____ Date _____

PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT

This office accepts insurance and I understand that I am responsible for payment of services rendered and also responsible for paying any co-payments and deductibles that my insurance does not cover. I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature _____ Date _____

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CD and the ADA.

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