

# 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 \_\_\_\_\_

Home Address \_\_\_\_\_  
\_\_\_\_\_

Birth date \_\_\_\_\_ SS# \_\_\_\_\_

Single  Married  Divorced  Widowed  Separated

HM# (\_\_\_\_) \_\_\_\_\_ CELL# (\_\_\_\_) \_\_\_\_\_

WK# (\_\_\_\_) \_\_\_\_\_ EXT \_\_\_\_\_

E-Mail \_\_\_\_\_

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 \_\_\_\_\_  
\_\_\_\_\_

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 thin 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: \_\_\_\_\_