# Welcome

*Thank you for choosing our practice for your dental needs. 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 and your family.*

## ① About You

Name ______________________________ Mr. Mrs. Ms. Dr.

I prefer to be called ____________________ male ☐ female ☐

Birth date____/____/____ SS# ____________________

Home Address ______________________________

______________________________

If you are a student: school/college ____________________

Hm phone# ____________________ pager/other ____________

Wk phone# ____________________ ext ____________

Do you prefer to receive calls at: ☐ home ☐ work

Are you: ☐ minor ☐ married ☐ single ☐ divorced ☐ widowed ☐ separated

You/your parents employer ____________________

Occupation ____________________

Business address ____________________

***Whom may we thank for referring you?***

______________________________

Other Family Members seen by us ____________________

______________________________

## ② Spouse or Parent Information

Name ______________________________

Wk place ______________________________

Wk phone ____________________ SS# ____________

Name ______________________________

Wk place ______________________________

Wk phone ____________________ SS# ____________

Person Responsible for Account ____________________

Relationship ______________________________

Phone and address if different than yours ____________________

______________________________

Employer ____________________ Wk# ____________

SS# ____________________ Birth date____/____/____

## ③ Dental Insurance

Name of insured ______________________________

Relationship ____________________ SS# ____________

Insured's employer ______________________________

Insurance Co. Name ______________________________

Insurance Co. Address ______________________________

______________________________

Group# ____________________ ID# ____________

How much is your deductible? ____________________

Maximum Benefit ____________ used ____________

## ④ Secondary Insurance

Name of insured ______________________________

Relationship ____________________ SS# ____________

Insured's employer ______________________________

Insurance Co. Name ______________________________

Insurance Co. Address ______________________________

______________________________

Group# ____________________ ID# ____________

How much is your deductible? ____________________

Maximum Benefit ____________ used ____________

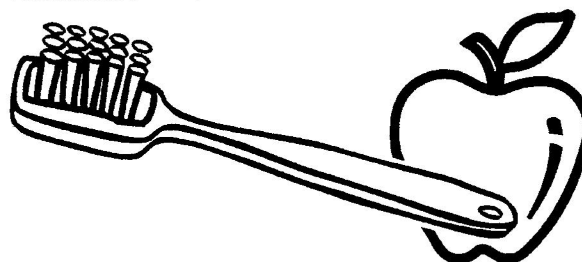
## ⑤ Neighbor or Relative not living with you:

Name ____________________ Relation ____________

Wk# ____________________ Hm# ____________

Address ______________________________

______________________________



# Confidential

## ⑥ *Dental History*

Why have you come to the dentist today? ____________________

____________________

____________________

Previous/present dentist ____________________

Date of last exam ____________ Full mouth x-rays ____________

Do you need to premedicate before dental treatment? ____________

Have you ever had an unpleasant dental experience? ____________

Please add anything you feel is important: ____________________

____________________

Please check any of the following that apply to you or your child:

- ☐ bad breath
- ☐ clicking/popping jaw
- ☐ food collection
- ☐ grinding teeth
- ☐ bleeding gums
- ☐ thumb sucking
- ☐ loose/broken fillings
- ☐ periodontal treatment
- ☐ sensitivity to cold
- ☐ sensitivity to hot
- ☐ sores or growth in mouth
- ☐ other ____________

## ⑦ *Medical History*

Do you have a personal physician? ☐ yes ☐ no

Physician's name ____________________

Phone # ____________ Date of last exam ____________

Do you smoke or use tobacco in any form? ____________

Please list all medications you are currently taking: ____________

____________________

____________________

For women: Are you taking birth control pills? ____________

Are you pregnant? ____________ Nursing? ____________

Have you ever had any of the following diseases:

- ☐ Abnormal Bleeding
- ☐ Alcohol/Drug Abuse
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Bones/Joints/Valves
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Transfusion
- ☐ Cancer/Chemotherapy
- ☐ Colitis
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting Spells
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Herpes/Fever Blisters
- ☐ High Blood Pressure
- ☐ HIV+/AIDS
- ☐ Jaw Pain
- ☐ Hospitalization
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Pace Maker
- ☐ Psychiatric Problems
- ☐ Radiation Treatment
- ☐ Rheumatic/Scarlet Fever
- ☐ Seizures
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease

Please 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 Anesthetics
- Y N Erythromycin
- Y N Latex
- Y N Penicillin
- Y N Tetracycline
- Y N Other ____________

____________

Is there anything you would like to discuss with the Doctor in Private?

____________________

I certify 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 strictest confidence and it is my responsibility to inform this office of any change in my/my child's medical status.

____________________ Date ____________

I certify that I/my child is covered by the above insurance and I assign directly to Dr.____________ all insurance benefits otherwise payable to me. I understand that I am responsible for the payment of services rendered. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

____________________ Date ____________

I authorize the dental staff to perform the necessary dental services I/my child may need; however, I understand I will be informed prior to treatment.

____________________ Date ____________

**--office use only office use only office use only office use only office use only office use only --**

I verbally reviewed the medical and dental information above with the patient named herein ____________ Date ____________

I have read my medical history dated ________ and confirm that it states past and present medical conditions ____________ Date ____________

I have read my medical history dated ________ and confirm that it states past and present medical conditions ____________ Date ____________

I have read my medical history dated ________ and confirm that it states past and present medical conditions ____________ Date ____________

I have read my medical history dated ________ and confirm that it states past and present medical conditions ____________ Date ____________