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: _____

I prefer to be called: _____

Circle one: Male Female

Birthdate: ___/____/_____ Age: _____

SS#_____ Email:_____

Home Address: _____

_____

Circle one:

Single Married Divorced Widowed

Hm#: (___) _____Cell#: (___)_____

Wk#: (____) _____ Other:_____

Employer: _____

Address: _____

How long there? ____ Occupation:_____

Where & When are best times to reach you?

_____

Other family members seen by us?

_____

Previous/Present Dentist: _____

Last Visit Date: _____

Whom may we thank for referring you? _____

IN THE EVENT OF AN EMERGENCY, IS THERE SOMEONE WHO LIVES NEAR YOU THAT WE SHOULD CONTACT?

His/Her Name: _____

Wk#: (___) _____ Cel#: (___) _____

Hm#: (___) _____

Spouse Information

His/Her Name: _____

Employer: _____

Wk#: (____) _____ Cell#: (___)_____

SS#:_____ Birthdate: ___/___/_____

Insurance Coverage

Primary

Insurance Co. Name:_____

Tel#: (___)_____ Group #:_____

Subscriber's Name:_____

Subscriber's Birthdate: ___/___/_____

Relation_____ SS#/ID#: _____

Subscriber's Employer: _____

Secondary

Insurance Co. Name:_____

Tel#: (___)_____ Group #:_____

Subscriber's Name:_____

Subscriber's Birthdate: ___/___/_____

Relation_____ SS#/ID#:_____

Subscriber's Employer: _____

Person Responsible For Account: _____

Wk#:(___)_____ Hm#: (___)_____

Billing Address: _____

_____

Relation:_____ SS#:_____

Medical History

Do you have a personal physician?_____

Physician's Name: _____

Phone#: (___) _____ Last Visit: _____

Your Current Physical Health Is? (Circle One)

Good Fair Poor

Are You Currently Under The Care Of A Physician? ___

If yes, for what reason? _____

Are you taking any prescriptions/over-the-counter medication?

_____

_____

Do you smoke or use tobacco in any other form?_____

For Women

Are you taking birth control pills?_____

Are you pregnant? _____ Week#?_____

Are you nursing? _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

Yes	No	Abnormal Bleeding
Yes	No	Alcohol/Drug Abuse
Yes	No	Anemia
Yes	No	Arthritis
Yes	No	Artificial Bones/Joints/Valves
Yes	No	Asthma
Yes	No	Blood Transfusion
Yes	No	Cancer/Chemotherapy
Yes	No	Colitis
Yes	No	Congenital Heart Defect
Yes	No	Diabetes
Yes	No	Difficulty Breathing
Yes	No	Emphysema
Yes	No	Epilepsy
Yes	No	Fainting Spells
Yes	No	Frequent Headaches
Yes	No	Glaucoma
Yes	No	Hay Fever
Yes	No	Heart Attack
Yes	No	Heart Murmur
Yes	No	Heart Surgery
Yes	No	Hemophilia
Yes	No	Hepatitis
Yes	No	Herpes/Fever Blisters
Yes	No	High Blood Pressure
Yes	No	HIV+/Aids
Yes	No	Hospitalized For Any Reason
Yes	No	Kidney Problems
Yes	No	Liver Disease
Yes	No	Low Blood Pressure
Yes	No	Pacemaker
Yes	No	Psychiatric Problems
Yes	No	Radiation Treatment
Yes	No	Rheumatic/Scarlet Fever
Yes	No	Seizures
Yes	No	Shingles
Yes	No	Sickle Cell Disease/Traits
Yes	No	Sinus Problems
Yes	No	Stroke
Yes	No	Thyroid Problems
Yes	No	Tuberculosis (TB)
Yes	No	Ulcers
Yes	No	Venereal Disease

Do you take any osteoporosis medication?

Yes No

Boniva Fosomax Bisphosphonate

Other_____

Please list any serious medical condition(s) that you have ever had:

_____

_____

_____

*Are you allergic to any of the following?

Yes	No	Aspirin
Yes	No	Codeine
Yes	No	Dental Anesthetics
Yes	No	Erythromycin
Yes	No	Tetracycline
Yes	No	Latex
Yes	No	Metals
Yes	No	Penicillin

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

_____

Dental History

Why have you come to the dentist today? _____

_____

Do you require antibiotics before dental treatment?____

Are you currently in any pain? _____

Have you ever had a serious/ difficult problem associated with any previous dental work?_____

Do you now or have you ever experienced pain/discomfort in your jaw (TMJ/TMD)?_____

Your dental health is: Good Fair Poor

Do your gums ever bleed? Yes No

How many times a day do you brush? _____ How many times a day do you floss? _____

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 informed consent.

This office accepts dental insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductibles that my insurance does not cover.

Signature_____ Date_____

For Official Use Only

I verbally reviewed the medical/dental information above with the patient named herein.

Initials:_____ Date:_____

Doctor's Comments: