

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 serve you.

1 About You

Today's Date: _____

E-mail address: _____

Name: _____
LAST FIRST MI MR MRS MS DR

I prefer to be called: _____ Male Female

Birthdate: ____/____/____ Age: ____ SS #: _____

Home Address: _____
APT/CONDO #

CITY STATE ZIP

Single Married Divorced Widowed Separated

Hm #: _____ Pager/Cell #: _____

Wk #: _____ Ext: _____ DL #: _____

Employer: _____

Employers 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: ____/____/____ Drivers License #: _____

Person Responsible for Account: _____

Wk #: _____ Ext: _____ Hm #: _____

Billing Address: _____

Relation #: _____ SS #: _____

Employer: _____ DL #: _____

3 Insurance Coverage

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: _____

Secondary

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: _____

**In case of an emergency, is there someone
 who lives near you that we should contact?**

His / Her name: _____ Relation: _____

Wk #: _____ Hm#: _____

4 Medical History

Do you have a personal physician? Yes No

Physician Name: _____

Phone #: _____ Date of last visit: _____

Are you currently under the care of a physician? Yes No

Please explain: _____

Continued on back

4 Medical History *continued*

Your current physical health is? Good Fair Poor

Are you taking any prescription/over-the-counter or herbal supplement drugs? Yes No

Please list each one: _____

Have you ever taken Fosamax or any other bisphosphonate? Yes No

Have you ever taken Phen-fen? Yes No

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 one 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 Bones / Joint / 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:

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 other drugs/materials that you are allergic to: _____

5 Dental History

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 / TMD)? Yes No

Your current dental health is? Good Fair Poor

Do you like your smile? Yes No

Would you like a whiter smile? Yes No Fresher Breath? Yes No

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

Type of bristles? Soft Medium Hard

Do you smoke or use tobacco in any other form? Yes No

6 Consent

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: _____

Payment is due in full at the time of treatment unless prior arrangements have been approved.

7 Payment

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: _____

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: _____

Doctors Comments: _____

MEDICAL HISTORY UPDATE

1. Date: _____ Comments: _____ Signature: _____

2. Date: _____ Comments: _____ Signature: _____

3. Date: _____ Comments: _____ Signature: _____