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.

① Patient Information

Today's Date: _____

Name: _____

Referred By: _____

❒ Male ❒ Female Birthdate: ___/___/___ Age: ___

SS#: _____

Home Address: _____

_____ Zip _____

❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Separated

Hm #: (____)_____ Pager/Cell: _____

Wk.#: (____)_____ Ext: _____ DL#: _____

Employer: _____

Employer's Address: _____

_____ Zip _____

Occupation: _____

Where & when are the best times to reach you? _____

_____

Previous/Present Dentist: _____

Last Visit Date: _____

② Dental Insurance

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____)_____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: __/__/__ Insured's SS #: _____

Insured's Employer: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____)_____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: __/__/__ Insured's SS #: _____

Insured's Employer: _____

③ Spouse Information

His/Her Name: _____

Employer: _____

Wk.#: (____)_____ Ext: _____ SS#: _____

Birthdate: ___/___/___ DL#: _____

Person Responsible for Account: _____

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

Billing Address: _____

Relation: _____ SS #: _____

Employer: _____ DL#: _____

④ Medical History

Do you have a personal physician? ❒ Yes ❒ No

Physician's Name: _____

Phone #: (_ _)_____ **Last Visit Date:** _____

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

Please Explain: _____

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

His/Her Name: _____ Relation: _____

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

⑤ Medical History

Your current physical health is:
❒ Good ❒ Fair ❒ Poor

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

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

Please list each one: _____

_____

Have you ever taken Phen-Fen? ❒ Yes ❒ No

(Also known as Redux or Pondimin) if yes, when? _____

For Women: Are you taking birth control pills?
❒ 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 Alcohol/Drug Use
Y N Anemia
Y N Arthritis
Y N Artificial Bones/Joints /Valves
Y N Asthma
Y N Blood Transfusion
Y N Cancer/Chemotherapy
Y N Colitis
Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Emphysema
Y N Epilepsy
Y N Fainting Spells
Y N Frequent Headaches
Y N Glaucoma
Y N Hay Fever
Y N Heart Attack
Y N Heart Murmur
Y N Heart Surgery
Y N Hemophilia
Y N Hepatitis
Y N Herpes/Fever Blisters
Y N High Blood Pressure
Y N HIV+/AIDS
Y N Hospitalized for any Reason
Y N Kidney Problems
Y N Liver Disease
Y N Low Blood Pressure
Y N Lupus
Y N Mitral Valve Prolapse
Y N Pacemaker
Y N Psychiatric Problems
Y N Radiation Treatment
Y N Rheumatic/Scarlet Fever
Y N Seizures
Y N Shingles
Y N Sickle Cell Disease
Y N Sinus Problems
Y N Stroke
Y N Thyroid Problems
Y N Tuberculosis (TB)
Y N Ulcers
Y N Venereal Disease

Please list any 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 Jewelry/Metals
Y N Latex
Y N Penicillin
Y N Tetracycline
Y N Other

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

_____

_____

⑥ Dental History

Why have you come to the dentist today?

Has your doctor told you that you require antibiotics before dental treatment? ❒ Yes ❒ No

Are you currently in pain? ❒ Yes ❒ No

Have you ever had a serious/difficult problem associated with any previous dental work? ❒ Yes ❒ No

Do you of 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

Do your gums ever bleed? ❒ Yes ❒ No

~~How many~~ times ~~a week do you floss?~~ _____

How many times a day do you brush? _____

Type of bristles? ❒ Hard ❒ Medium ❒ Soft

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 of confidence and it is my responsibility to inform this office of any changed 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 time of treatment unless prior arrangements have been approved.

! Thank you for filling out this form completely. It will enable us to help you more effectively. If you have a question at any time, please ask us.

We are happy to help.

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 OFFICE USE ONLY **OFFICE USE ONLY** OFFICE USE ONLY **OFFICE USE ONLY**

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

Doctor's Comments: _____

_____

MEDICAL HISTORY UPDATE

1. Date: _____ **Comments:** _____ **Signature:** _____

2. Date: _____ **Comments:** _____ **Signature:** _____

3. Date: _____ **Comments:** _____ **Signature:** _____