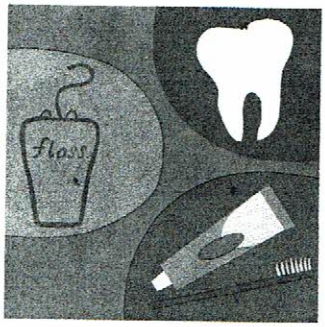
WELCOME

TO OUR PRACTICE!



Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

Today's Date _____ Patient # _____

PATIENT INFORMATION

☐ Mr. ☐ Mrs. ☐ Ms ☐ Miss ☐ Dr.

Name _____

Address _____

City / State / Zip _____

How Long at Current Address? _____ SS # _____

Phone # _____ Cell Phone _____ Email _____

Birth Date _____ Age _____ ☐ Male ☐ Female

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Single ☐ Dependent

RESPONSIBLE PARTY (if other than patient)

Relationship to Patient _____

Name _____

Address _____

City / State / Zip _____

How Long at Current Address _____ SS # _____

Phone # _____ Birth Date _____ Age _____ ☐ Male ☐ Female

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

EMPLOYMENT INFORMATION

Employer _____ Work Phone _____

Occupation _____ How Long at Current Job? _____

INSURANCE

Insurance Company _____

Address _____

City / State/ Zip _____

Phone # _____

Insured's Employer _____

Insured's Name _____

Relationship to Patient _____

Insured's SS# or Membership # _____

POLICY / GROUP NUMBER _____

INSURANCE

Insurance Company _____

Address _____

City / State/ Zip _____

Phone # _____

Insured's Employer _____

Insured's Name _____

Relationship to Patient _____

Insured's SS# or Membership # _____

POLICY / GROUP NUMBER _____

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name (Last, First, M.I.): _____

Previous or referring Doctor: _____

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

Date of last physical exam: _____

PERSONAL HEALTH INFORMATION

Do you smoke or use tobacco In any other form? Yes ☐ No ☐	**Have you ever taken Fosamax, Actonel, Boniva, or any other biphosphonate?** Yes ☐ No ☐	**Have you ever taken any dietary supplements such as Phen/Phen?** Yes ☐ No ☐
	For Women: Are you using any type of birth control? Yes ☐ No ☐ **Are you Pregnant?** Yes ☐ No ☐ **Are you nursing?** Yes ☐ No ☐	

Are you currently taking any prescription medications or over the counter? Yes ☐ No ☐
Please list below prescribed drugs and over-the-counter drugs, such as vitamins and inhalers:

Name the Drug	Strength	Frequency Taken

Allergies: Such as Aspirin, Codeine, Dental anesthetics, Antibiotics, Jewelry metals, Latex or any other? Yes ☐ No ☐

Name the Drug	Reaction You Had

Have you ever had any of the following disease or medical problems? (Please check option that applies)

Y ☐	N ☐	Anemia/Radiation Treatment	Y ☐	N ☐	Hemophelia / Abnormal Bleeding
Y ☐	N ☐	Artificial Bones / Joints / Valves	Y ☐	N ☐	Hepatitis A / B / C
Y ☐	N ☐	Arthritis	Y ☐	N ☐	High / Low Blood Pressure
Y ☐	N ☐	Asthma	Y ☐	N ☐	HIV + / Aids
Y ☐	N ☐	Blood Transfusion	Y ☐	N ☐	Hospitalized for any reason
Y ☐	N ☐	Cancer / Chemotherapy	Y ☐	N ☐	Kidney Problems
Y ☐	N ☐	Congenital Heart Failure	Y ☐	N ☐	Mitral Valve Prolapse
Y ☐	N ☐	Diabetes	Y ☐	N ☐	Psychiatric Problems
Y ☐	N ☐	Difficulty Breathing	Y ☐	N ☐	Rheumatic / Scarlet Fever
Y ☐	N ☐	Drug / Alcohol Abuse	Y ☐	N ☐	Severe / Frequent Headaches
Y ☐	N ☐	Emphysema / Glaucoma	Y ☐	N ☐	Shingles
Y ☐	N ☐	Epilepsy / Seizures / Fainting Spells	Y ☐	N ☐	Sickle Cell Disease / Traits
Y ☐	N ☐	Fever Blisters / Herpes	Y ☐	N ☐	Sinus Problems
Y ☐	N ☐	Heart Attack / Stroke	Y ☐	N ☐	Tuberculosis (TB)
Y ☐	N ☐	Heart Murmur	Y ☐	N ☐	Ulcers / Colitis
Y ☐	N ☐	Heart Surgery / Pacemaker	Y ☐	N ☐	Venereal Disease

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

_____

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

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 ☐

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 ☐

Do your gums ever bleed? Yes ☐ No ☐

Have you ever had periodontal disease? Yes ☐ No ☐

How many times a week do you floss? _____

How many times a day do you brush? _____

Type of bristles? Soft ☐ Medium ☐ Hard ☐

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.

Patient Signature _____ Date _____

We will bill your insurance as a courtesy; your portion of payment is due at the time services are rendered. If insurance does not remit payment within the allotted time, the patient is responsible for all charges.

Thank you for filling out this form completely. It will enable us to help your more effectively. If you have questions 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.

Doctor Signature _____ Date _____