# 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 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:** _____

Employer's 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: ___/___/___ Driver's 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 the event 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's 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 been told that you snore or hold your breath while sleeping or wake up gasping for breath? ☐ 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 any 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 / Joints / 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 Treatment |
| 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 whiter teeth? ☐ 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

## I

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.**

## !

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** 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: _____