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: ____

I prefer to be called: ______________________ ☐Male ☐Female

Birthday: ____________ Age: _____ SS #: __________________

Home Address: ____

____

☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Hm #: _____________________ Cell #: ______________________

Wk #: _____________________ Ext: ______ DL #: ____________

Employer: ____

Employer's Address: _______________________________________

How long there? __________ Occupation: ____________________

Where and when are the best times to reach you? _______________

Whom may we Thank for referring you? ____________________

Other family members seen by us: ____________________________

Previous / Present Dentist: ______________________________

Last Visit Date: ____

2 Spouse Information

His / Her Name: _______________________________________

Employer: ____

Wk #: ________________ Ext: _____ SS # __________________

Birthday: _____________________ DL #: ___________________

Person Responsible for Account: _________________________

Wk #: ________________ Ext: _____ Hm #: _________________

Billing Address: ____

Relation: _____________________ SS #: ____________________

Employer: _____________________ DL #: ___________________

3 How did you hear about our office?

☐Yellow Pages ☐News Letter ☐Internet ☐Walk-In ☐Radio ☐Other: ______________________________

☐Referred By: ____________________________________
(Name of the person that referred you)

☐Professional Referral: ____________________________
(Name of Doctor, Dentist, Office, etc…that referred you)

4 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 Birthday: _______________ Insured's ID # ____________

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 Birthday: _______________ Insured's ID # ____________

Insured's Employer: _______________________________________

5 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 should be contacted?

His / Her Name: ____________________ Relation: ______________

Wk #: _______________________ Hm #: ______________________

CONTINUED ON BACK

6 Medical History
continued

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

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

Are you taking any prescription / over-the-counter drugs or herbal supplements? ☐ 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 any of the following diseases or medical problems?

	Y	N		Y	N
Abnormal Bleeding*	☐	☐	Hepatitis	☐	☐
Alcohol / Drug Abuse	☐	☐	Herpes / Fever Blisters	☐	☐
Anemia	☐	☐	High Blood Pressure	☐	☐
Arthritis	☐	☐	HIV+ / AIDS	☐	☐
Artificial Bones /Joints /Valves	☐	☐	Hospitalized for Any Reason	☐	☐
Asthma	☐	☐	Kidney Problems	☐	☐
Bacterial Endocarditis*	☐	☐	Liver Disease	☐	☐
Cancer / Chemotherapy	☐	☐	Low Blood Pressure	☐	☐
Colitis	☐	☐	Lupus	☐	☐
Congenital Heart Defect*	☐	☐	Mitral Valve Prolapse*	☐	☐
Diabetes	☐	☐	Pacemaker*	☐	☐
Difficulty Breathing	☐	☐	Psychiatric Problems	☐	☐
Emphysema	☐	☐	Radiation Treatment	☐	☐
Epilepsy	☐	☐	Seizures	☐	☐
Fainting Spells	☐	☐	Shingles	☐	☐
Frequent Headaches	☐	☐	Sickle Cell Disease	☐	☐
Glaucoma	☐	☐	Sinus Problems	☐	☐
Hay Fever	☐	☐	Stroke	☐	☐
Heart Attack	☐	☐	Thyroid Problems	☐	☐
Heart Murmur*	☐	☐	Tuberculosis (TB)	☐	☐
Heart Surgery	☐	☐	Ulcers	☐	☐
Hemophilia	☐	☐	Venereal Disease	☐	☐

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

____

____

Are you allergic to any of the following?

Y N Aspirin Y N Erythromycin Y N Penicillin
Y N Codeine Y N Jewelry / Metals Y N Tetracycline
Y N Dental Anesthetics Y N Latex Y N Other

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

____

____

____

____

____

7 Dental History

Primary Reason for this dental appointment:

☐ Examination ☐ Emergency ☐ Consultation

Explain: ______________________________________

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 or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No

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

Do your gums ever bleed? ☐ Yes ☐ No

Do you like your smile? ☐ Yes ☐ No

Do you like the color of your teeth? ☐ Yes ☐ No

Do you have any fear or anxiety with getting dental work done? ☐ Yes ☐ No

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 strictest of 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 and I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me.

____

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 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.

MEDICAL HISTORY UPDATE

1. Date: __________ Comments: ______________________

Signature: ______________________________

2. Date: __________ Comments: ______________________

Signature: ______________________________

I understand that I am required to give 48 hours' notice of my intent to cancel any existing appointment and that I may be charged a $50 office fee if I cancel with less than a 48 hours' notice. If I fail to show for my appointment a $50 fee may be applied as well.

____

Signature (Patient or Guardian) *Date*

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

Doctor's Comments: ______________________________________