Welcome

1 About You

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 so we can better care for you.

Today's Date: ______________________ I prefer to be called: ______________________ ☐ Male ☐ Female

Name: ______________________
Last First MI Mr Mrs Ms Dr

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

E-mail Address: ______________________ Birthdate:___/___/___ Age: _____ SS #: ______________

Home Address: ______________________
Street City State Zip

Home Phone#: ( ) __________ Pager/Cell#: ( ) __________ Work Phone #: ( ) __________ Driver License #: __________

Where and when are best times to reach you? ______________ Who may we **thank** for referring you? ______________

Other family members seen by us: ______________________

Previous/Present Dentist: ______________________ Last Visit Date: ______________
(Please Circle)

Employer: ______________________ How long there? __________ Occupation: ______________

Employer's Address: ______________________
Street/PO Box City State Zip

2 Dental Insurance

Primary Insurance

Medical Coverage? ☐ Yes ☐ No Dental Coverage? ☐ Yes ☐ No Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: ______________________ Phone #: ( ) __________ Group # (Plan, Local or Policy #): __________

Insurance Co. Address: ______________________
Street/PO Box City State Zip

Insured's Name: ______________ Insured's SS #: ______________ Insured's Birthdate:___/___/___Relation: __________

Insured's Employer: ______________ Employer's Address: ______________________
Street/PO Box City State Zip

Secondary Insurance

Medical Coverage? ☐ Yes ☐ No Dental Coverage? ☐ Yes ☐ No Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: ______________________ Phone #: ( ) __________ Group # (Plan, Local or Policy #): __________

Insurance Co. Address: ______________________
Street/PO Box City State Zip

Insured's Name: ______________ Insured's SS #: ______________ Insured's Birthdate:___/___/___Relation: __________

Insured's Employer: ______________ Employer's Address: ______________________
Street/PO Box City State Zip

3 Spouse Information

His/Her Name: ______________________ Birthdate:___/___/___ Social Security #: ______________

Employer ______________________ Work Phone #: ( ) __________ Ext: __________ Drivers License #: __________

Continued on back

3 Spouse Information-Continued

Employer: ______________________ How long there? ________ Occupation: ______________

Employer's Address: ____
Street/PO Box City State Zip

Where and when are best times to reach you? ______________ Who may we **thank** for referring you? ______________

4 Medical History

Do you have a personal physician? ☐ No ☐ Yes

Physician's Name ______________________

Phone #: ______________ Date of last visit: ______________

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

Name: ______________ Relation: ______________

Wk #: ______________ Home #: ______________

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

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

Please explain ______________________

Are you taking any prescription / over-the-counter drugs? ☐ No ☐ Yes

Please list each one ______________________

Have you ever had any of the following diseases or medical problems?

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

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

____

Are you allergic to any of the following drugs?

Y N Aspirin	Y N Erythromycin	Y N Tetracycline
Y N Codeine	Y N Latex	Y N Other
Y N Dental Anesthetics	Y N Penicillin	

Please list any other drugs that you are allergic to: ______________________

____

For Women

Are you taking birth control pills? ☐ No ☐ Yes

Are you pregnant? ☐ No ☐ Yes Week # ______________

Are you nursing? ☐ No ☐ Yes

5 Dental History

Why have you come to the dentist today?

____

____

Are you currently in pain? ☐ No ☐ Yes

Are your teeth sensitive to heat or cold? ☐ No ☐ Yes

Have you ever had a serious / difficult problem associated with any previous dental work?

☐ No ☐ Yes

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)?

☐ No ☐ Yes

Your current dental health is

☐ Good ☐ Fair ☐ Poor

Do you like your smile?

☐ No ☐ Yes

Do your gums ever bleed?

☐ No ☐ Yes

Have you ever had periodontal disease? ☐ No ☐ Yes

How many times a week do you floss? ______________

How many times a day do you brush? ______________

Type of bristles?

☐ Hard ☐ Medium ☐ Soft

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help.

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

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 with my informed consent, any necessary dental services I may need during diagnosis and treatment.

Signature Date

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