Welcome!

Please print this form, fill it out completely and bring it with you to your first office visit., Thank you!

1 ABOUT YOU

Today's Date_____

E-mail Address: _____

Name: _____

I prefer to be called: _____ ❑ Male ❑ Female

Birthdate ____/____/____ Age: ____ SSN: _____

Home Address: _____

_____

❑ Single ❑ Married ❑ Partnered ❑ Divorced/Separated ❑ Widowed

Home #: ( )_____ Cell #: ( )_____

Work # ( )_____Ext.: _____ DL#:_____

Employer: _____

Employers Address: _____

_____

How long there? _____ Occupation:_____

Where and when are best times to reach you? _____

_____

Whom may we Thank for referring you? _____

Other family members seen by us: _____

Previous/Present Dentist: _____

Person Responsible for Account: _____

2 SPOUSE INFORMATION

Name: _____

Employer: _____

Work # ( )_____Ext.: _____ DL#:_____

Birthdate ____/____/____ Age: ____ SSN: _____

Relative or Friend not living with you.

His/Her Name:

Relation:

Wk#: ( ) _____ Hm# ( ) _____

3 INSURANCE

Primary Insurance

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: _____

Employer's Address: _____

_____

Secondary Insurance

Dental Coverage: ❑ YES ❑ NO

Insurance Co. Phone #: ( ) _____

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

Insured's Name:_____

Relation:_____

Insured's Birthdate: ____/____/____

Insured's ID #:_____

Insured's Employer:_____

Employer's Address:_____

_____

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. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

_____

Signature Date

4 MEDICAL HISTORY

Do you have a personal physician? ❑ YES ❑ NO

Physician's Name: _____

Phone #: ( ) _____ Date of last visit: _____

Your current medical health is: **Good** **Fair** **Poor**

Are you currently under the care of a physician? ❑ YES ❑ NO

Please explain: _____

Do you smoke or use tobacco in any other form? ❑ YES ❑ NO

Have you had any metal rods, pins or implants? ❑ YES ❑ NO

Are you taking any prescription / over-the-counter drugs? ❑ YES ❑ NO

Please list each one: _____

Have you ever taken Phen-Fen? (Also known as Redux or Pandimin) ❑ YES ❑ NO

If so, when? _____

Have you ever taken Fosomax, or any other bisphosphonate? ❑ 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/Hemophilia	Y N	Herpes / fever Blisters
Y N	AIDS	Y N	High Blood Pressure
Y N	Alcohol / Drug Abuse	Y N	HIV
Y N	Anemia	Y N	Hospitalized for any reason
Y N	Arthritis	Y N	Kidney Problems
Y N	Artificial Bones/Joints/Valves	Y N	Liver Disease
Y N	Asthma	Y N	Low Blood Pressure
Y N	Blood Transfusion	Y N	Lupus
Y N	Cancer/Chemotherapy	Y N	Mitral Valve Prolapse
Y N	Colitis	Y N	Pacemaker
Y N	Congenital Heart Disease	Y N	Psychiatric Problems
Y N	Diabetes	Y N	Radiation treatment
Y N	Difficulty Breathing	Y N	Rheumatic / Scarlet Fever
Y N	Emphysema	Y N	Seizures
Y N	Epilepsy	Y N	Shingles
Y N	Fainting Spells	Y N	Sickle Cell Disease / traits
Y N	Frrequent Headaches	Y N	Sinus Problems
Y N	Glaucoma	Y N	Stroke
Y N	Hay Fever	Y N	Thyroid Problems
Y N	Heart Attack / Surgery	Y N	Tuberculosis (TB)
Y N	Heart Murmur	Y N	Ulcers
Y N	Hepatitis	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	Penicillin
Y N	Codeine	Y N	Jewelry/Metals	Y N	Sulfur
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? _____

Are you currently in pain? ❑ YES ❑ NO

Do you require antibiotics before dental treatment? ❑ YES ❑ NO

Your current dental health is: ❑ **Good** ❑ **Fair** ❑ **Poor**

Have you ever had a serious/difficult problem associated with any previous dental work? ❑ YES ❑ NO

Do you floss daily? ❑ YES ❑ NO

Do you brush daily? ❑ YES ❑ NO

Type of bristles on your tyoothbrush? ❑ Hard ❑ Med. ❑ Soft

Have you ever had gum treatment? ❑ YES ❑ NO

Do your gums ever bleed? ❑ YES ❑ NO

Do your gums ever itch? ❑ YES ❑ NO

Have you ever had periodontal Disease? ❑ YES ❑ NO

Do you now or have you ever experienced pain/ discomfort in your jaw joint [TMJ/TMDJ]? ❑ YES ❑ NO

Are your teeth sensitive to heat, cold or anything else? _____

Do you have any loose teeth? ❑ YES ❑ NO

Do you still have wisdom teeth? ❑ YES ❑ NO

Would you like fresher breath? ❑ YES ❑ NO

Would you like whiter teeth? ❑ YES ❑ NO

Are you happy with the way your smile looks? ❑ YES ❑ NO

If not, what would you change? _____

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 bve held in the strictest confidence and it is my responsibility to imform 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

OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information with the patient named herein.

Initials: _____ Date: _____

Doctor's Comments: _____

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

MEDICAL HISTORY UPDATE

Has there been any change in your health status since your last visit? Y N

If Yes, please explain: _____

Patient Signature Date

Dentist Signature Date

Has there been any change in your health status since your last visit? Y N

If Yes, please explain: _____

Patient Signature Date

Dentist Signature Date