

# 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 these forms completely. The better we communicate the better we can care for you.

## 1 ABOUT YOU

Today's Date: \_\_\_\_\_

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

Home #: \_\_\_\_\_ Pager/Other #: \_\_\_\_\_

WK #: \_\_\_\_\_ Ext: \_\_\_\_\_ DL #: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

How long there? \_\_\_\_\_ Occupation: \_\_\_\_\_

Where & when are best times to reach you? \_\_\_\_\_

Who may we Thank for referring you? \_\_\_\_\_

Other family members seen by us: \_\_\_\_\_

Previous / Present Dentist: \_\_\_\_\_  
(Please Circle)

Last Visit Date: \_\_\_\_\_

## 2 SPOUSE INFORMATION

Their Name: \_\_\_\_\_

Employer: \_\_\_\_\_

WK #: \_\_\_\_\_ Ext: \_\_\_\_\_ SS #: \_\_\_\_\_

Birthdate: \_\_\_\_\_ DL #: \_\_\_\_\_

Person Responsible for Account: \_\_\_\_\_

WK #: \_\_\_\_\_ Ext: \_\_\_\_\_ HM #: \_\_\_\_\_

Billing Address: \_\_\_\_\_

Relationship: \_\_\_\_\_ SS # \_\_\_\_\_

Employer: \_\_\_\_\_ DL #: \_\_\_\_\_

## 3 DENTAL INSURANCE

### Primary Dental Insurance

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone #: \_\_\_\_\_

Group # (Plan, Local, Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Insured's Birthday: \_\_\_/\_\_\_/\_\_\_ Insured's SS#: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

### Secondary Dental Insurance

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone #: \_\_\_\_\_

Group # (Plan, Local, Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Insured's Birthday: \_\_\_/\_\_\_/\_\_\_ Insured's SS#: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

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

Their Name: \_\_\_\_\_ Relation: \_\_\_\_\_

WK #: \_\_\_\_\_ HM #: \_\_\_\_\_

## 4 MEDICAL HISTORY

Do you have a personal physician?  No  Yes

Physician's Name: \_\_\_\_\_

Phone #: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

CONTINUED ON BACK OF FORM

# 4 MEDICAL HISTORY *cont.*

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: \_\_\_\_\_

For Women:

Are you taking birth control pills?  No  Yes

Are you pregnant?  No  Yes      Week # \_\_\_\_\_

Are you nursing?  No  Yes

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

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

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

\_\_\_\_\_

\_\_\_\_\_

### Are you allergic to any of the following:

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

Please list any other drugs that you are allergic to: \_\_\_\_\_

\_\_\_\_\_

# 5 DENTAL HISTORY

Why have you come to the dentist today? \_\_\_\_\_

\_\_\_\_\_

Are you currently in pain?  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

How many times a week do you floss? \_\_\_\_\_ a day do you brush? \_\_\_\_\_

Type of bristles?  Hard  Medium  Soft

**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 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 with my informed consent that I may need during diagnosis and treatment.

Signature \_\_\_\_\_

Date \_\_\_\_\_

**Payment is due in full at the 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 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.

## 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 \_\_\_\_\_