

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 serve you.

1. ABOUT YOU

Today's Date _____

Full Name: _____

I prefer to be called _____ M F

Birthdate ___/___/___ Age ___ SS# ___-___-_____

Home Address: _____

Single Married Divorced Widowed Separated

Hm # _____ Cell/Other _____

Wk # _____ ext. _____ DL # _____

Employer _____

How long there? _____ Occupation _____

Where & when are the best times to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us _____

Previous Dentist _____ Ph # _____

Last Visit Date _____ Last X-rays Date _____

2. Account Information

Person responsible for Account(if different than patient) _____

Hm # _____ Wk # _____ ext _____

Billing Address _____

Relation to you _____ SS # ___-___-_____

Employer _____ DL # _____

3. DENTAL INSURANCE

PRIMARY DENTAL INSURANCE

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone # _____

Group # (Plan, Local or Policy #) _____

Insured's Name _____ Birthdate ___/___/___

Relation to you _____ Insured's SS# ___-___-_____

Insured's Employer _____

SECONDARY DENTAL INSURANCE

WE NO LONGER FILE SECONDARY INSURANCE.

4. Medical Information

Do you have a personal physician? Yes No

Physician's Name _____

Address _____

Phone # _____ Last Visit Date ___/___/___

Who to call in case of emergency _____

Hm # _____ Wk # _____ ext _____

Relation to you _____

5. Medical History

Your current physical health is Good Fair Poor

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

If yes, please explain _____

Please list all prescription / over-the-counter medications that you are currently taking _____

For Women: Are you taking birth control pills? Yes No

Are you pregnant? Yes No Week # _____

Are you nursing? Yes No

Circle any medical conditions that you have or have had.

Abnormal Bleeding	Herpes/Fever Blisters
Alcohol/Drug Abuse	High Blood Pressure
Anemia	HIV+ / AIDS
Arthritis	Hospital Stay
Asthma	Joint Replacement
Blood Transfusion	Kidney Problems
Cancer/Chemotherapy	Liver Disease
Colitis	Low Blood Pressure
Congenital Heart Defect	Mitral Valve Prolapse
Diabetes	Osteoporosis
Difficulty Breathing	Pacemaker/Defibrillator
Emphysema	Psychiatric Problems
Epilepsy	Radiation Treatment
Fainting Spells	Rheumatic Fever
Frequent Headaches	Seizures
Glaucoma	Shingles
Hay Fever	Sickle Cell Disease
Heart Attack	Sinus Problems
Heart Murmur	Stroke
Heart Surgery	Thyroid Problems
Hemophilia	Tuberculosis (TB)
Hepatitis	Ulcers
	Venereal Disease

Please list any other medical conditions that you have ever had _____

Do you use any form of tobacco? Yes No

Do you drink beverages containing alcohol? Yes No

If so, _____ # drinks per: day / week / month

Are you allergic to any of the following?

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

Please list any other medications/food that you are allergic to _____

6. Dental History

Why have you come to the dentist today?

Do you need to be premedicated with 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 you floss daily? Yes No **Brush Daily?** Yes No

Type of Bristles on your toothbrush? Hard Medium Soft

How long do you use your toothbrush before replacing it? _____

Do you use anything in addition to your brush and floss?

If yes, what? _____

Do your gums ever bleed? Yes No

Have you ever had periodontal disease? Yes No

Do you have mobility in your teeth? Yes No

Does food get caught between your teeth? Yes No

Are your teeth sensitive to heat or cold? Yes No

Are your teeth sensitive to sweets? Yes No

Are your teeth sensitive to chewing / biting? Yes No

Do you still have your wisdom teeth? Yes No

Have you lost any teeth? Yes No

If yes, how? _____

Have you had orthodontic treatment? Yes No

If yes, when? _____

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 be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status.

Signature _____

Date _____