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 can communicate, the better we can care for you.

1. ABOUT YOU

Today's Date: ______________

Name: ______________________________
LAST FIRST MI

I prefer to be called: ______________ ☐ Male ☐ Female

Birthdate: ___/___/___ Age: ____ SS#: __________

Home address: ______________________________

____
CITY STATE ZIP

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home #: (____) ______________________

Work #: (____) ______________________ Ext.: ______

Other #: (____) ______________________

Employer:

____

Employer's Address:

____

How Long? ________ Occupation: ______________

Where & when are best times to reach you?

____

Whom may we Thank for referring you?

____

Spouse's Name: ______________________________

Other family members seen by us: ______________

____

2. DENTAL INSURANCE

Primary Dental Insurance

Insurance Company's:
Name: ______________________________

Address: ______________________________

Phone #: (____)______________________

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

Insured's Information:
Name: ______________________________

Relation: ______________________________

Birthdate: ___/___/___ SS #: __________

Employer: ______________________________

Secondary Dental Insurance

Insurance Company's:
Name: ______________________________

Address: ______________________________

Phone #: (____)______________________

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

Insured's Information:
Name: ______________________________

Relation: ______________________________

Birthdate: ___/___/___ SS #: __________

Employer: ______________________________

3. ACCOUNT INFO

Person ultimately responsible for account

Name: ______________________________

Relation: ______________________________

Billing Address: ______________________________

____
CITY STATE ZIP

SS #: ______________________________

Drivers License #: ______________________

Work Phone #: (____) ______________

4. IN EVENT OF EMERGENCY

Who should we contact? ______________________

Relation: ______________________________

Home #: (____) ______________________

Work #: (____) ______________________

Who is your Medical Doctor? ______________________

M.D.'s Phone #: (____) ______________________

Please Continue on Back

MEDICAL/DENTAL INFORMATION

What brings you in to see the dentist today?

____

Are you currently in pain? ☐ No ☐ Yes How Long? ______________

Do you require pre-medication? ☐ Yes ☐ No ☐ Don't Know

Have you ever had a problem with previous dental work? ☐ Yes ☐ No

Please check any of the following problems:

☐ Discomfort, clicking or popping in jaw
☐ Red, swollen of bleeding gums
☐ Sensitive Teeth
☐ Broken/Chipped Teeth
☐ Other ______________
☐ Lost/Broken Fillings
☐ Teeth Grinding
☐ Bad Breath
☐ Stained/Discolored Teeth

When was your last Dental Exam? ________ Last Dental X-rays? ________

Times a Day you Brush? ________ Times a Week you floss? ________

Type of toothbrush bristles you use: ☐ Soft ☐ Medium ☐ Hard

How would you rate your smile? (1-10) ______

What would you like to do to improve your smile? ______________

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

____
Signature Date

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

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

Do you have or have you ever had any of the following diseases or medical conditions?

Y N Heart Attack/Stroke	**Y N** Kidney Problems	**Y N** Cancer/Tumor	**Y N** Chemotherapy
Y N Heart Surgery	**Y N** Pacemaker	**Y N** Asthma	**Y N** Sinus Problems
Y N Heart Murmur	**Y N** Respiratory Problem	**Y N** Hepatitis	**Y N** Diabetes/Hypoglycemia
Y N Heart Disease	**Y N** Ulcer	**Y N** HIV+/AIDS	**Y N** Leukemia
Y N Rheumatic Fever	**Y N** Psychiatric Problems	**Y N** Anemia	**Y N** Arthritis/Rheumatism
Y N Mitral Valve Prolapse	**Y N** Venereal Disease	**Y N** Emphysema	**Y N** Frequent Neck Pain
Y N Artificial Valves	**Y N** Tuberculosis TB	**Y N** Glaucoma	**Y N** Severe Headaches
Y N Artificial Bones/Joints	**Y N** Scarlet Fever	**Y N** Chest Pain	**Y N** Seizures/Epilepsy
Y N High/Low Blood Pressure	**Y N** Back Problems	**Y N** Fainting	**Y N** Alcohol/Drug Abuse
Y N Congenital Heart Defect	**Y N** Fever Blister/Herpes	**Y N** Shingles	**Y N** Jaw Problems TMJ/TMD

Please List any other medical condition(s) you have or ever had: ______________

Are you allergic to any of the following? ☐ Latex ☐ Penicillin ☐ Tetracycline ☐ Aspirin ☐ Dental Anesthetics ☐ Others: ______________

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

Please list each one: ______________________________

Have you ever taken the drug Phen-fen and or Redux? ☐ Yes ☐ No

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

Are you pregnant? ☐ Yes ☐ No Week #: ________

Are you nursing? ☐ Yes ☐ No

OFFICE USE ONLY 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/Hygienist's Comments: ______________________________

Medical History Update

Date: ________ Comments: ______________________ Signature: ____________

Date: ________ Comments: ______________________ Signature: ____________

Date: ________ Comments: ______________________ Signature: ____________