Welcome

ABOUT YOU

Today's Date _____

Name: _____ I prefer to be called: _____ ○ Male ○ Female
Last First MI Mr Mrs Ms Dr

Birthdate: ___/___/___ Age: _____ Social Security # _____ ○ Single ○ Married ○ Divorced ○ Widowed ○ Separated

Home Address: _____
Street City State Zip

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

Email address: _____ Driver License #: _____

Where & when are best times to reach you? _____ Whom may we Thank for referring you? _____

Other family members seen by us: _____

Employer: _____ Work #:(_____) _____ Occupation: _____

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

SPOUSE INFORMATION

His / Her Name: _____ Birthdate: ___/___/___ Social Security #: _____

Employer: _____ Work Phone #:(_____) _____ Ext. ___ Drivers License #: _____

INSURANCE INFORMATION

Primary Insurance Medical Coverage? ○ Yes ○ No Dental Coverage? ○ Yes ○ No Orthodontic Coverage? ○ Yes ○ No

Insurance Co. Nome _____ Phone #: (_____) _____ Group # (Plan, Local or Policy #): _____

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

Insured's Name: _____ Insured's Social Security #: _____ Insured's Birthday: ___/___/___ Relation: _____

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

Person Responsible for Account if other than yourself

Name: _____ Relation: _____ Home Phone # (_____) _____ Social Security #: _____

Employer: _____ Work Phone #: (_____) _____ Ext. ____ Drivers License #: _____

Billing Address: _____
Street City State Zip

CONTINUED ON BACK

ABOUT YOU

Why have you come to the dentist today? _____

Are you currently in pain?	○ Yes	○ No
Do you need to be premedicated before dental treatment?	○ Yes	○ No
Have you experienced problems associated with any previous dental work?	○ Yes	○ No
Do you now 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 a toothbrush before replacing it? _____

Do you use anything in addition to your brush and floss? ◉ Yes ○ No

If yes, what? _____

MEDICAL HISTORY

Do you have a personal physician? ○ Yes ○ No

Physician's Name: _____

Address: _____
Street City State Zip

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

Your current physical 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

Are you allergic to any of the following: (○ Yes ○ No)

○○ Aspirin	○○ Erythromycin	○○ Sedatives
○○ Barbiturates	○○ Jewelry	○○ Sulfa Drugs
○○ Codeine	○○ Latex	○○ Tetracycline
○○ Dental Anesthetics	○○ Penicillin	○○ Other

Please list additional drugs that cause allergic reactions: _____

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

Are you pregnant? ○ Unsure ○ Yes ○ No

Week #_____ Are you nursing? ○ Yes ○ No

Are you taking any of the following:

Acetaminophen	○ Yes	○ No	Blood Thinners	○ Yes	○ No	Insulin/Diabetes Drugs	○ Yes	○ No	Thyroid Medicine	○ Yes	○ No
Antibiotics	○ Yes	○ No	Blood Pressure Medication	○ Yes	○ No	Nitroglycerin	○ Yes	○ No	Tranquilizers	○ Yes	○ No
Antihistamines	○ Yes	○ No	Cold Remedies	○ Yes	○ No	Recreational Drugs	○ Yes	○ No			
Aspirin	○ Yes	○ No	Digitalis/Heart Medication	○ Yes	○ No	Steroids/Cortisone	○ Yes	○ No			

If yes, how often and how many milligrams? _____

Are you taking any prescription / over-the-counter drugs not listed above? ○ Yes ○ No If yes, please list each one: _____

_____

_____

Do you or have you experienced the following: (○ Yes ○ No)

○○ Abnormal Bleeding	○○ Colitis	○○ Headaches	○○ Liver Disease	○○ Shingles
○○ Alcohol Abuse	○○ Congenital Heart Defect	○○ Heart Attack	○○ Low Blood Pressure	○○ Sickle Cell Disease
○○ Anemia	○○ Diabetes	○○ Heart Murmur	○○ Lupus	○○ Sinus Problems
○○ Arthritis	○○ Difficulty Breathing	○○ Heart Surgery	○○ Mitral Valve Prolapse	○○ Stroke
○○ Artificial Bones/Joints	○○ Drug Abuse	○○ Hemophilia	○○ Pacemaker	○○ Thyroid Problems
○○ Artificial Valves	○○ Emphysema	○○ Hepatitis	○○ Persistent Cough	○○ Tonsillitis
○○ Asthma	○○ Epilepsy	○○ Herpes	○○ Psychiatric Problems	○○ Tuberculosis (TB)
○○ Blood Transfusion	○○ Fainting Spells	○○ High Blood Pressure	○○ Radiation Treatment	○○ Ulcers
○○ Cancer	○○ Fever Blisters	○○ HIV+ / AIDS	○○ Rheumatic Fever	○○ Venereal Disease
○○ Chemotherapy	○○ Glaucoma	○○ Hospitalized for Any Reason	○○ Scarlet Fever	
○○ Chicken Pox	○○ Hay Fever	○○ Kidney Problems	○○ Seizures	

Please list any serious medical condition(s) that you have experienced: _____

AUTHORIZATIONS

I affirm that the information I have given is correct to the best of my knowledge. It 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 the necessary dental services I may need.

_____
Signature Date

INSURANCE

I understand that my insurance is an agreement between my insurance company and me. I also understand that I am responsible for the balance of my dental account regardless of my insurance.

_____
Signature Date

PAYMENT IS DUE AT TIME OF SERVICE