

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. Name _____ 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:

Y N Aspirin	Y N Erythromycin	Y N Sedatives
Y N Barbiturates	Y N Jewelry	Y N Sulfa Drugs
Y N Codeine	Y N Latex	Y N Tetracycline
Y N Dental Anesthetics	Y N Penicillin	Y N 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 <input type="checkbox"/> Yes <input type="checkbox"/> No	Blood Thinners <input type="checkbox"/> Yes <input type="checkbox"/> No	Insulin/Diabetes Drugs <input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Medicine <input type="checkbox"/> Yes <input type="checkbox"/> No
Antibiotics <input type="checkbox"/> Yes <input type="checkbox"/> No	Blood Pressure Medication <input type="checkbox"/> Yes <input type="checkbox"/> No	Nitroglycerin <input type="checkbox"/> Yes <input type="checkbox"/> No	Tranquilizers <input type="checkbox"/> Yes <input type="checkbox"/> No
Antihistamines <input type="checkbox"/> Yes <input type="checkbox"/> No	Cold Remedies <input type="checkbox"/> Yes <input type="checkbox"/> No	Recreational Drugs <input type="checkbox"/> Yes <input type="checkbox"/> No	
Aspirin <input type="checkbox"/> Yes <input type="checkbox"/> No	Digitalis/Heart Medication <input type="checkbox"/> Yes <input type="checkbox"/> No	Steroids/Cortisone <input type="checkbox"/> Yes <input type="checkbox"/> 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:

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

PAYMENT IS DUE AT TIME OF SERVICE

Date