

welcome

About You

Today's Date: _____

E-mail Address: _____

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: _____

Home Phone #: (____) _____^{Street} Cell/other #: (____) _____^{City} Work Phone #: (____) _____^{State} Ext: _____^{Zip} Driver's License #: _____

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

Other family members seen by us: _____

Employer: _____ How long there? _____ Occupation: _____

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

Neighbor or Relative not living with you

His / Her Name: _____ Relation: _____ Work Phone #: (____) _____ Home Phone #: (____) _____

Address: _____
Street City State Zip

Spouse Information

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

Employer: _____ Work Phone #: (____) _____ Ext: _____ Driver's License #: _____

Insurance Information

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

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

Insurance Co. Address: _____

Insured's Name: _____^{Street/PO Box} Insured's Social Security #: _____^{City} Insured's Birthdate: ___/___/___^{State} Relation: _____^{Zip}

Insured's Employer: _____ Employer's Address: _____

Street/PO Box City State Zip

Secondary Insurance Dental Coverage? Yes No Orthodontic Coverage? Yes No Medical Coverage? Yes No

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

Insurance Co. Address: _____

Insured's Name: _____^{Street/PO Box} Insured's Social Security #: _____^{City} Insured's Birthdate: ___/___/___^{State} Relation: _____^{Zip}

Insured's Employer: _____ Employer's Address: _____

Street/PO Box City State Zip

CONTINUED ON BACK

Dental History

Why have you come to the dentist today? _____

Are you currently in pain? Yes No
 Do you require antibiotics before dental treatment? 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
 Do your gums ever bleed? Yes No Ever Itch? Yes No
 Have you ever had periodontal disease? Yes No

Are your teeth sensitive to heat, cold, or anything else? _____
 Do you have mobility in your teeth? Yes No
 Do you still have wisdom teeth? Yes No
 Previous / Present Dentist: _____ Last Visit Date: _____
 (Please Circle)
 Would you like fresher breath? Yes No Whiter teeth? Yes No
Are you happy with the way your smile looks? Yes No
 If not, what would you change? _____

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
 Have you ever taken Phen-Fen, Redux or Pondimin? Yes No
For Women: Are you taking birth control pills? Yes No
 Are you pregnant? Unsure Yes No
 Week #: _____ Are you nursing? Yes No

Do you or have you experienced the following?

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

Please list any serious medical condition(s) that you have experienced: _____
 Are you taking any prescription/over the counter drugs? Yes No If yes, please list each one: _____

Are you allergic to any of the following?

Y N Aspirin	Y N Codeine	Y N Erythromycin	Y N Latex	Y N Sedatives	Y N Tetracycline
Y N Barbiturates	Y N Dental Anesthetics	Y N Jewelry / Metals	Y N Penicillin	Y N Sulfa Drugs	Y N Other

Please list anything additional that causes allergic reactions: _____

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need. I assign the Doctor all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover. I have received a copy of this offices Notice of Privacy Practices.

Signature

Date