

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 care for you.

## ABOUT YOU

Today's Date: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

**Name:** \_\_\_\_\_  
Last First MI Mr. Mrs. Ms. Dr.

I prefer to be called: \_\_\_\_\_  Male  Female

Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_\_

SS#: \_\_\_\_\_

Home Address: \_\_\_\_\_  
Apt./Condo #

Single  Married  Divorced  Widowed  Separated

Hm #: ( ) \_\_\_\_\_ Pager/Cell #: \_\_\_\_\_

Wk #: ( ) \_\_\_\_\_ Ext: \_\_\_\_\_ DL #: \_\_\_\_\_

**Employer:** \_\_\_\_\_

Employer's Address: \_\_\_\_\_

How long there? \_\_\_\_\_ Occupation: \_\_\_\_\_

Where & when are best times to reach you? \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_  
(Please Circle)

Other family members seen by us: \_\_\_\_\_

Previous/Present Dentist: \_\_\_\_\_

Last Visit Date: \_\_\_\_\_

What do you look for in a dental office?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

How would you rate your smile?

1 2 3 4 5 6 7 8 9 10  
LOW HIGH

Explain \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## DENTAL INSURANCE

### Primary Dental Insurance

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone #: ( ) \_\_\_\_\_

Group # (Plan, Local or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Relation: \_\_\_\_\_

Insured's Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Insured's ID #: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

## SPOUSE INFORMATION

His/Her Name: \_\_\_\_\_

Employer: \_\_\_\_\_

Wk #: ( ) \_\_\_\_\_ Ext: \_\_\_\_\_ SS #: \_\_\_\_\_

Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ DL #: \_\_\_\_\_

**Person Responsible for Account:** \_\_\_\_\_

Wk #: ( ) \_\_\_\_\_ Ext: \_\_\_\_\_ Hm #: ( ) \_\_\_\_\_

Billing Address: \_\_\_\_\_

Relation: \_\_\_\_\_ SS #: \_\_\_\_\_

Employer: \_\_\_\_\_ DL #: \_\_\_\_\_

## EMERGENCY CONTACT

**In the event of an emergency, is there someone who lives near you that we should contact?**

His/Her Name: \_\_\_\_\_

Relation: \_\_\_\_\_

Wk #: ( ) \_\_\_\_\_

Hm #: ( ) \_\_\_\_\_

## MEDICAL HISTORY

Do you have a personal physician?  Yes  No

Physician's Name: \_\_\_\_\_

Wk #:(\_\_\_\_\_) Date of last visit: \_\_\_\_\_

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

Please Explain: \_\_\_\_\_  
\_\_\_\_\_

Your current physical health is:  Good  Fair  Poor

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

Please list each one: \_\_\_\_\_  
\_\_\_\_\_

Do you smoke or use tobacco in any other form?  Yes  No

Have you ever taken Fosamax, Actonel, Boniva or any other bisphosphonate?  Yes  No

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

Are you pregnant?  Yes  No If yes, week #: \_\_\_\_\_

Are you nursing?  Yes  No

### Have you ever had any of the following diseases or medical problems? (Please circle option that applies)

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

Please list any serious medical condition(s) that you have ever had:  
\_\_\_\_\_  
\_\_\_\_\_

### Are you allergic to any of the following?

- |                        |                      |                  |
|------------------------|----------------------|------------------|
| Y N Aspirin            | Y N Erythromycin     | Y N Penicillin   |
| Y N Codeine            | Y N Jewelry / Metals | Y N Tetracycline |
| Y N Dental Anesthetics | Y N Latex            | Y N Other        |

Please list any other drugs/materials that you are allergic to: \_\_\_\_\_  
\_\_\_\_\_

## DENTAL HISTORY

### Why have you come to the dentist today?

\_\_\_\_\_

\_\_\_\_\_

Do you require 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 now or have you ever experienced pain or discomfort in your jaw joint (TMJ/TMD)?  Yes  No

Your current dental health is:  Good  Fair  Poor

Do you like your smile?  Yes  No

Do your gums ever bleed?  Yes  No

Have you ever had periodontal disease?  Yes  No

How many times a week do you floss? \_\_\_\_\_

How many times a day do you brush? \_\_\_\_\_

Type of bristles preferred:  Hard  Medium  Soft

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 \_\_\_\_\_

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have questions at any time, please ask us. We are happy to help.

**Payment is due in full at the time of treatment unless prior arrangements have been approved.**

## OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein. Initials: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor's Comments: \_\_\_\_\_  
\_\_\_\_\_

### Medical History Update

1. Date: \_\_\_\_\_ Comments: \_\_\_\_\_

Signature: \_\_\_\_\_

1. Date: \_\_\_\_\_ Comments: \_\_\_\_\_

Signature: \_\_\_\_\_

1. Date: \_\_\_\_\_ Comments: \_\_\_\_\_

Signature: \_\_\_\_\_