

ABOUT YOU

Today's Date: _____

First Name: _____

Last Name: _____

I prefer to be called: _____

Male Female SS#: _____

Title: Miss Ms. Mrs. Mr. Dr. Other _____

Address: _____

City: _____ State: _____

ZIP: _____ Date of Birth: ____/____/____

Single Married Divorced Widowed Separated

Home Phone: () _____

Work Phone: () _____

Cell Phone: () _____

E-mail address: _____

How would you like appointments confirmed? (Circle all that apply):
Home Phone Cellphone Text Message E-Mail

When and where are best times to reach you?

Summer Address:

City: _____ State: _____ ZIP: _____

Phone: () _____

Employer: _____

Employer's Address: _____

Occupation: _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____

Last Dental Visit Date: _____

SPOUSE / RESPONSIBLE PERSON INFORMATION

Spouse Name: _____

Employer: _____

Work #: _____ Ext.: _____

Birthdate: _____

Person Responsible for Account: _____

Relationship: _____

Employer: _____

SS#: _____

DENTAL INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone # _____

Group # (Plan, Local or Policy #) _____

Insured's Name: _____ Relation: _____

Insured's Employer: _____

Insured's Birthdate: ____/____/____

Insured's ID# or SS#: _____

Employers Address: _____

SECONDARY DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone # _____

Group # (Plan, Local or Policy #) _____

Insured's Name: _____ Relation: _____

Insured's Employer: _____

Insured's Birthdate: ____/____/____

Insured's ID# or SS#: _____

Employers Address: _____

MEDICAL HISTORY

Do you have a primary care physician? **Y N**

Physician's Name: _____

Physician's Phone #: _____

Are you currently under the care of a physician? **Y N**

Please explain: _____

Your current physical health is : **Good Fair Poor**

Do you smoke or use tobacco in any other form? **Y N**

Have you ever taken Fosamax or any other bisphosphonate? **Y N**

Have you ever taken Phen-Fen? **Y N**

For Women: Are you using a prescribed method of birth control? **Y N**

Are you Pregnant? **Y N** Are you nursing? **Y N**

Are you taking any prescription or over-the-counter or supplemental drugs? If yes, please list each one:

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

Have you ever had any of the following disease or medical problems? (If yes, please circle option that applies)

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

Are you allergic to any of the following?

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

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

In the event of an emergency, is there someone that we should contact?

His / Her Name: _____

Relation: _____ Wk.# _____

Home # _____ Cell # _____

DENTAL HISTORY

Why have you come to the dentist today?

Do you require antibiotics before dental treatment? **Y N**

Are you currently in pain? **Y N**

Have you ever had a serious / difficult problem with any previous dental work? **Y N**

Do you now or have you every experienced pain / discomfort in your jaw joint? (TMJ/TMD) **Y N**

Do you like your smile? **Y N**

If your teeth look crooked, spaced or crowded, does it bother you? **Y N**

Do your gums ever bleed? **Y N**

Have you ever had periodontal disease? **Y N**

How many time a week do you floss? _____

How many times a day do you brush? _____

Type of bristles? 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 _____

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

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!