# WELCOME

## Personal Information

Today's Date _____ E-mail Address_____

**Name**_____
Last First Mi Mr. Mrs. Ms. Dr.

I prefer to be called: _____ _____ ☐ Male ☐ Female

Birth date: ____ /____ /____ Age: _____ SS# _____

Home Address _____

_____

☐ 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?_____

Other family members seen by us:_____

Previous/Present Dentist: _____
(please circle)

Last Visit Date:_____

## Spouse Information

His/Her Name:_____

Employer: _____

Wk#: (_____)_____ Ext: _____ SS#: _____

Birth date:____ /____ /____ DL#: _____

## Insurance

**Primary Insurance**

Medical Coverage? ☐ Yes ☐ No Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (_____)_____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____Relation: _____

Insured's Birth Date: ____ /____ /____ Insured's SS#:_____

Insured's Employer: _____

Insured's Address: _____

## Insurance Continued

**Secondary Insurance**

Medical Coverage? ☐ Yes ☐ No Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address:_____

Insurance Co. Phone #: (_____)_____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____Relation: _____

Insured's Birth Date:____ /____ /____ Insured's SS#:_____

Insured's Employer: _____

Insured's Address: _____

## Person to contact if you are not available

His/Her Name:_____ Relation:_____

Wk#: (_____)_____ Hm#:(_____)_____

Address: _____

_____

City:_____ State:_____ Zip:_____

## 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

Have you ever had gum treatment? ☐ 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 like your smile? ☐ Y ☐ N Do your gums ever bleed? ☐ Y ☐ N

How many times a week do you floss? _____

How many times a day do you brush? _____

Type of bristles? ☐ Soft ☐ Medium ☐ Hard

**PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT**

unless prior arrangements have been approved.

If this office accepts insurance. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I acknowledge that appropriate credit reports may be obtained when deemed necessary for the extension of credit towards dental treatment. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

_____
Signature Date

# MEDICAL HISTORY

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐ Yes ☐ No If Yes, _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If Yes, _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If Yes, _____

Are you taking any medications, pills or drugs? ☐ Yes ☐ No If Yes, _____

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No

Are you on a special diet? ☐ Yes ☐ No

Do you use controlled substances? ☐ Yes ☐ No

Women: Are you... ☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

| | | | |
|---|---|---|---|
| ☐ Aspirin | ☐ Penicillin | ☐ Codeine | ☐ Acrylic |
| ☐ Metal | ☐ Latex | ☐ Sulfa Drugs | ☐ Local Anesthetics |
| ☐ Hydrocodone | ☐ Clindamycin | ☐ Keflex | ☐ Azythromycin (z-pack) |
| ☐ Cephalexin | ☐ Red Dye | ☐ Cinnamon | |

☐ Other? If Yes, _____

Do you have, or have you had, any of the following?

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AIDS/HIV Positive ☐ Yes ☐ No | Cortisone Medicine ☐ Yes ☐ No | Hemophilia ☐ Yes ☐ No | Radiation Treatments ☐ Yes ☐ No |
| Alzheimer's Disease ☐ Yes ☐ No | Diabetes ☐ Yes ☐ No | Hepatitis A ☐ Yes ☐ No | Recent Weight Loss ☐ Yes ☐ No |
| Anaphylaxiz ☐ Yes ☐ No | Drug Addiction ☐ Yes ☐ No | Hepatitis B or C ☐ Yes ☐ No | Renal Dialysis ☐ Yes ☐ No |
| Anemia ☐ Yes ☐ No | Easily Winded ☐ Yes ☐ No | Herpes ☐ Yes ☐ No | Rheumatic Fever ☐ Yes ☐ No |
| Angina ☐ Yes ☐ No | Emphysema ☐ Yes ☐ No | High Blood Pressure ☐ Yes ☐ No | Rheumatism ☐ Yes ☐ No |
| Arthritis/Gout ☐ Yes ☐ No | Epilepsy or Seizures ☐ Yes ☐ No | High Cholesterol ☐ Yes ☐ No | Scarlet Fever ☐ Yes ☐ No |
| Artificial Heart Valve ☐ Yes ☐ No | Excessive Bleeding ☐ Yes ☐ No | Hives or Rash ☐ Yes ☐ No | Shingles ☐ Yes ☐ No |
| Artificial Joint ☐ Yes ☐ No | Excessive Thirst ☐ Yes ☐ No | Hypoglycemia ☐ Yes ☐ No | Sickle Cell Disease ☐ Yes ☐ No |
| Asthma ☐ Yes ☐ No | Fainting Spells/Dizziness ☐ Yes ☐ No | Irregular Heartbeat ☐ Yes ☐ No | Sinus Trouble ☐ Yes ☐ No |
| Blood Disease ☐ Yes ☐ No | Frequent Cough ☐ Yes ☐ No | Kidney Problems ☐ Yes ☐ No | Spina Bifida ☐ Yes ☐ No |
| Blood Transfusion ☐ Yes ☐ No | Frequent Diarrhea ☐ Yes ☐ No | Leukemia ☐ Yes ☐ No | Stomach/Intestinal Disease ☐ Yes ☐ No |
| Breathing Problems ☐ Yes ☐ No | Frequent Headaches ☐ Yes ☐ No | Liver Disease ☐ Yes ☐ No | Stroke ☐ Yes ☐ No |
| Bruise Easily ☐ Yes ☐ No | Genital Herpes ☐ Yes ☐ No | Low Blood Pressure ☐ Yes ☐ No | Swelling of Limbs ☐ Yes ☐ No |
| Cancer ☐ Yes ☐ No | Glaucoma ☐ Yes ☐ No | Lung Disease ☐ Yes ☐ No | Thyroid Disease ☐ Yes ☐ No |
| Chemotherapy ☐ Yes ☐ No | Hay Fever ☐ Yes ☐ No | Mitral Valve Prolapse ☐ Yes ☐ No | Tonsillitis ☐ Yes ☐ No |
| Chest Pains ☐ Yes ☐ No | Heart Attack/Failure ☐ Yes ☐ No | Osteoporosis ☐ Yes ☐ No | Tuberculosis ☐ Yes ☐ No |
| Cold Sores/Fever Blisters ☐ Yes ☐ No | Heart Murmur ☐ Yes ☐ No | Pain in Jaw Joints ☐ Yes ☐ No | Tumors or Growths ☐ Yes ☐ No |
| Congenital Heart Disorder ☐ Yes ☐ No | Heart Pacemaker ☐ Yes ☐ No | Parathyroid Disease ☐ Yes ☐ No | Ulcers ☐ Yes ☐ No |
| Convulsions ☐ Yes ☐ No | Heart Trouble/Disease ☐ Yes ☐ No | Psychiatric Care ☐ Yes ☐ No | Venereal Disease ☐ Yes ☐ No |
| Yellow Jaundice ☐ Yes ☐ No | | | |

Have you ever had any serious illness not listed above? ☐ Yes ☐ No ☐ N/A _____

Comments _____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

**X** **Date:**