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: _____

Email Address: _____

Name: _____
Last First Mi Mr/Mrs/Ms/Dr

I prefer to be called: _____ ❑Male ❑Female

Birthdate: ___/___/___ Age:_____ SS#_____

Home Address: _____

_____
City State Zip

❑Single ❑Married ❑Divorced ❑Widowed ❑Separated

Hm #:(___)_____ Cell #:_____

Wk #: (___)_____ Ext: ___ DL#:_____

Employer:_____

Whom may we Thank for referring you?

_____

_____

Other family members seen by us:

_____

_____

EMERGENCY INFORMATION

His/Her Name: _____

Employer: _____

Wk #:(___)_____ Ext: ___

INSURANCE

Primary Insurance

Dental Coverage? ❑Si ❑No

Insurance Co. Name: _____

Insurance Co. Address: _____

_____

Insurance Co. Phone #: (___)_____

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

Insured's Name: _____

Relation:_____

Insured's Birthday_____/_____/_____

Insured's ID #: _____

Insured's Employer: _____

Person Responsible for Account:

Wk #: (___)_____ Ext: _____ Hm #:(___)_____

Billing Address: _____

Relationship:_____

MEDICAL HISTORY

Are you currently under the care of a physician?

❑Si ❑No

Please Explain: _____

_____

_____

_____

_____

_____

MEDICAL HISTORY, Cont

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

Do you smoke or use tobacco in any form?

❑Yes ❑No

Have you had any metal rods, pins, or implants?

❑Yes ❑No

Are you taking any prescription/over-the-counter or herbal supplement drugs? ❑Yes ❑No

Please list each one: _____

_____

_____

For Women: Are you using a prescribed method of birth control? ❑Si ❑No Week #:_____

Have you ever had any of the following disease or medical problems?

Y N Abnormal Bleeding
Y N Alcohol/Drug Abuse
Y N Anemia
Y N Arthritis
Y N Artificial Bones/Joints/Values
Y N Asthma
Y N Blood Transfusion
Y N Cancer/Chemotherapy
Y N Colitis
Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Emphysema
Y N Epilepsy
Y N Fainting Spells
Y N Frequent Headaches
Y N Glaucoma
Y N Hay Fever
Y N Heart Attack
Y N Heart Surgery
Y N Hemophilia
Y N Hepatitis
Y N Herpes/Fever Blisters
Y N High Blood Pressure
Y N HIV+/AIDS
Y N Hospitalized for Any Reason
Y N Kidney Problems
Y N Liver Disease
Y N Low Blood Pressure
Y N Lupus
Y N Mitral Valve Pressure
Y N Pacemaker
Y N Psychiatric Problems
Y N Radiation Treatment
Y N Rheumatic/Scarlet Fever
Y N Seizures
Y N Shingles
Y N Sickle Cell Disease/Traits
Y N Sinus Problems
Y N Stroke
Y N Thyroid Problems
Y N Tuberculosis (TB)
Y N Ulcers
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 Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Latex
Y N Penicillin
Y N Tetracycline
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 associate 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

Are you sensitive to heat, cold, or anything else?

_____

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.

_____

Signature Date

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 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 the 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