Welcome

ABOUT YOU

Today's Date: _____ Cell #: (____)_____ 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: _____
Street City State Zip

Home Phone #: (____)_____ Cell #: (____)_____ Work Phone #: (____)_____ Ext: ____ Driver License #: _____

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

Other family members seen by us: _____

Employer: _____ 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

Person Responsible for Account if other than yourself

Name: _____ Relation: _____ Home Phone #: (____)_____ Social Security #: _____

Employer: _____ Work Phone #: (____)_____ Ext: ____ Drivers License #: _____

Billing Address: _____
Street City State Zip

SPOUSE INFORMATION

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

Employer: _____ Work Phone #: (____)_____ Ext: ____ Drivers License #: _____

INSURANCE INFORMATION

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

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

Insurance Co. Address: _____
Street/PO Box City State Zip

Insured's Name: _____ Insured's Social Security #: _____ Insured's Birthdate: ___/___/___ Relation: _____

Insured's Employer: _____

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

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

Insurance Co. Address: _____
Street/PO Box City State Zip

Insured's Name: _____ Insured's Social Security #: _____ Insured's Birthdate: ___/___/___ Relation: _____

Insured's Employer: _____

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

Have you experienced problems associated with any previous dental work? ☐ Yes ☐ No

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

Are your teeth sensitive to heat, cold, or anything else? _____

Do you brush daily? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

Would you like 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 ☐ 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

Are you allergic to any of the following?

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

Please list additional drugs/materials that cause allergic reactions: _____

_____

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

Are you pregnant? ☐ Unsure ☐ Yes ☐ No

Week #: _____ Are you nursing? ☐ Yes ☐ No

Are you taking any of the following?

Y N Acetaminophen	Y N Blood Thinners	Y N Insulin/Diabetes Drugs	Y N Thyroid Medicine
Y N Antibiotics	Y N Blood Pressure Medication	Y N Nitroglycerin	Y N Tranquilizers
Y N Antihistamines	Y N Cold Remedies	Y N Recreational Drugs	
Y N Aspirin	Y N Digitalis/Heart Medication	Y N Steroids/Cortisone	

Have you ever taken Fosamax or any other Bisphosphonates? ☐ Yes ☐ No

Are you taking any prescription/over-the-counter-drugs not listed above? ☐ Yes ☐ No

If yes, please list each one: _____

Do you or have you experienced the following?

Y N Abnormal Bleeding	Y N Diabetes	Y N Glaucoma	Y N Low Blood Pressure	Y N Stroke
Y N Alcohol Abuse	Y N Difficulty Breathing	Y N Headaches	Y N Lupus	Y N Thyroid Problems
Y N Anemia	Y N Difficulty Swallowing	Y N Heart Attack	Y N Mitral Valve Prolapse	Y N Tonsillitis
Y N Arthritis	Y N Dizziness	Y N Heart Murmur	Y N Pacemaker	Y N Tuberculosis (TB)
Y N Artificial Bones/Joints	Y N Drug Abuse	Y N Heart Surgery	Y N Persistent Cough	Y N Ulcers
Y N Artificial Valves	Y N Dry Mouth	Y N Hepatitis	Y N Psychiatric Problems	Y N Venereal Disease
Y N Asthma	Y N Emphysema	Y N Herpes	Y N Radiation Treatment	
Y N Blood Transfusion	Y N Epilepsy	Y N High Blood Pressure	Y N Rheumatic Fever	
Y N Cancer	Y N Excessive Thirst	Y N HIV+/AIDS	Y N Seizures	
Y N Chemotherapy	Y N Fainting Spells	Y N Hospitalized for Any Reason	Y N Shingles	
Y N Chest Pain	Y N Family history of diabetes, heart problems, tumors	Y N Kidney Problems	Y N Sickle Cell Disease	
Y N Chicken Pox		Y N Liver Disease	Y N Sinus Problems	
Y N Congenital Heart Defect	Y N Fen-Phen		Y N Steroid Therapy	

Please list any serious medical condition(s) that you have experienced: _____

AUTHORIZATIONS

I affirm that the information I have given is correct to the best of my knowledge. It 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 the necessary dental services I may need. My method of payment will be _____.

_____
Signature Date

PAYMENT IS DUE AT TIME OF SERVICE

I certify that I am covered by _____ Insurance Co. and I assign directly to Dr. _____ all insurance benefits, otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____
Signature Date

MEDICAL HISTORY UPDATE

1. Date: _____ Comments: _____ Signature: _____

2. Date: _____ Comments: _____ Signature: _____

3. Date: _____ Comments: _____ Signature: _____