

# Welcome!

The benefits of happy, Healthy smiles 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.

## 1 ABOUT YOU

Today's Date: \_\_\_\_\_ Email Address: \_\_\_\_\_  
Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ Soc. Sec. #: \_\_\_\_\_  
Driver License #: \_\_\_\_\_  
Name: \_\_\_\_\_  
(Last Name) (First Name) (Initial) (Mr., Mrs., Ms. or Dr.)  
Home Address: \_\_\_\_\_ APT / CONDO# \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Single  Married  Widowed  Divorced  Separated  
Home #: ( ) \_\_\_\_\_ Pager/Cell #: ( ) \_\_\_\_\_  
Work #: ( ) \_\_\_\_\_ Ext. \_\_\_\_\_  
Employer: \_\_\_\_\_  
Employer 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: \_\_\_\_\_

## 2 SPOUSE INFORMATION

His / Her Name: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Work #: ( ) \_\_\_\_\_ Ext: \_\_\_\_\_ Soc. Sec #: \_\_\_\_\_  
Cell Phone: ( ) \_\_\_\_\_ Birth date: \_\_\_/\_\_\_/\_\_\_  
Driver License #: \_\_\_\_\_

### Person responsible for account

Name: \_\_\_\_\_  
(Last Name) (First Name) (Initial)  
Relation: \_\_\_\_\_  
Birthdate: \_\_\_/\_\_\_/\_\_\_ Soc. Sec #: \_\_\_\_\_  
Billing Address: \_\_\_\_\_  
Work #: \_\_\_\_\_ ext: \_\_\_\_\_ Home #: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Driver License #: \_\_\_\_\_

## 3 DENTAL INSURANCE

### Primary Dental Insurance

Insurance Company Name: \_\_\_\_\_  
Insurance Company Address: \_\_\_\_\_  
Insurance Company Phone: ( ) \_\_\_\_\_  
Group # (Plan, Local or Policy#): \_\_\_\_\_  
Insured's Name: \_\_\_\_\_ Relation: \_\_\_\_\_  
Insured's Birth date: \_\_\_/\_\_\_/\_\_\_ Insured's ID #: \_\_\_\_\_  
Insured's Employer: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_

### Secondary Dental Insurance

Insurance Company Name: \_\_\_\_\_  
Insurance Company Address: \_\_\_\_\_  
Insurance Company Phone: ( ) \_\_\_\_\_  
Group # (Plan, Local or Policy#): \_\_\_\_\_  
Insured's Name: \_\_\_\_\_ Relation: \_\_\_\_\_  
Insured's Birth date: \_\_\_/\_\_\_/\_\_\_ Insured's ID #: \_\_\_\_\_  
Insured's Employer: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_

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

His/Her Name: \_\_\_\_\_  
Relation: \_\_\_\_\_  
Home #: \_\_\_\_\_ Work #: \_\_\_\_\_

## 4 MEDICAL HISTORY

Do you have a personal physician?  Yes  No

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

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

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

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

Continued on next page →



## MEDICAL HISTORY - Continued on next page

Your current Physical health is:  Good  Fair  Poor

Are you taking any prescription / over-the-counter or supplemental drugs?  Yes  No

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

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

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

Have you ever taken Phen-Fen?  Yes  No

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

Have you taken Viagra, Revati, Cialis or Levitra in the last 24 hours?  Yes  No

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

Are you pregnant?  Unsure  Yes  No

Week #: \_\_\_\_\_ Are you nursing?  Yes  No

**Have you ever had any of the following disease 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 Problem            |
| 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 / 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? \_\_\_\_\_ 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 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.

**Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.**

### OFFICE USE ONLY • OFFICE USE ONLY • OFFICE USE ONLY • 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: \_\_\_\_\_