Welcome!

The benefits of a happy and healthy smile are tremendous!
The goal of our office is to help you reach and maintain maximum oral health. Please fill out this form in its entirety. The more we know about you, the better we can serve you and your family.

ABOUT YOU, OUR PATIENT

Date _____

Name _____ ❑ male ❑ female SSN ____-____-____ Age _____
I prefer to be called _____ DOB ____/____/____ ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated
Home address _____
(street) (city) (state) (zip)

Hm# _____ Wk# _____ Ext# _____ Cell# _____
Email address _____ DL# _____
When and where is the best time to reach you? _____
Occupation _____ Employer _____ How long at present position ? _____
Employer's Address _____
(street) (city) (state) (zip)

Whom may we thank for referring you to us? _____

SPOUSE/PARENT INFO

His/Her name _____ Employer _____ Wk# _____
SSN ____-____-____ DL# _____ DOB ____/____/____

Person responsible for account _____ Relationship _____
Occupation _____ Employer _____
If different from above: Billing address _____
(street) (city) (state) (zip)

Hm# _____ Wk# _____ Ext# _____ SSN ____-____-____

DENTAL INSURANCE INFO

PRIMARY INSURANCE

Insurance Co. name _____ Insurance Co. phone# _____ Policy# _____
Insurance billing address _____
Insured's name _____ Relation _____ SSN ____-____-____ DOB ____/____/____

SECONDARY INSURANCE

Insurance Co. name _____ Insurance Co. phone# _____ Policy# _____
Insurance billing address _____
Insured's name _____ Relation _____ SSN ____-____-____ DOB ____/____/____

In the event of an emergency, is there someone that we may contact?
Name _____ Relation _____ Hm# _____ Wk# _____

MEDICAL HISTORY

Do you have a personal physician? ❑ yes ❑ no Physician's name _____ Ph# _____
Date of last visit _____ Your current health is ❑ good? ❑ fair? ❑ poor?
Are you taking any prescription/herbal or homeopathic drugs. ❑ no ❑ yes, please list _____
_____

Do you or have you ever experienced any of the following?

Y N Anemia / excess bleeding
Y N Artificial bones / joints
Y N Artificial heart valves
Y N Arthritis
Y N Asthma
Y N Blood transfusion
Y N Cancer
Y N Chemo-radiation therapy
Y N Congenital heart defect
Y N Diabetes
Y N Difficulty breathing
Y N Drug / alcohol problem
Y N Emphysema
Y N Epilepsy / seizures
Y N Fever blisters
Y N Heart surgery / pacemaker
Y N High / low blood pressure
Y N Heart attack / when ? _____
Y N Heart murmur
Y N Hepatitis Type _____
Y N Herpes
Y N HIV+ / AIDS
Y N Migraines
Y N Mitral valve prolapse
Y N Rheumatic fever
Y N Scarlet fever
Y N Severe headaches
Y N Shingles
Y N Sinus trouble
Y N Stroke
Y N Synthroid for thyroid
Y N Tuberculosis (TB)
Y N Ulcers
Y N Venereal Disease
Other _____
_____

Are you allergic to any of the following?

❑ Aspirin ❑ Codeine ❑ Dental Anesthetics ❑ Erythromycin
❑ Latex ❑ Penicillin ❑ Sulfa Drugs ❑ Tetracycline
❑ Other _____
Have you ever taken antibiotics prior to a dental procedure?
❑ no ❑ yes, explain _____

Women

Are you pregnant? ❑ no ❑ yes, due date _____
Are you taking Birth Control Pills ❑ yes ❑ no
Are you nursing? ❑ yes ❑ no

DENTAL HISTORY

Why have you come to the dentist today? _____
_____
Do you like your smile? ❑ yes ❑ no
If you could change anything about your teeth, what would it be?
_____
Do your gums bleed? ❑ yes ❑ no
How many times do you brush a day? _____ floss a week? _____
Are you currently in pain? ❑ yes ❑ no

Does your jaw ❑ click? ❑ pop? ❑ hurt? ❑ lock?
Have you ever had difficulties following a dental procedure?
❑ no ❑ yes, explain _____
_____
Have you ever had periodontal (gum) disease? ❑ yes ❑ no
Are any of your teeth loose? ❑ yes ❑ no
Are your teeth sensitive to ❑ hot? ❑ cold? ❑ sweets?

The information that I have given on this questionnaire is correct to the best of my knowledge. I understand that it is my responsibility to notify the office of any changes in my medical history. I also understand that all information given is to be held in the strictest confidence.

_____
(signature) (date)

I understand that I am responsible for payment for services rendered, AND I am responsible for deductibles and remaining balances that my insurance carrier does not cover.

_____
(signature) (date)

Annual Medical History Update (Sign and Date)

I have reviewed my medical history and made all the changes necessary. _____
I have reviewed my medical history and made all the changes necessary. _____
I have reviewed my medical history and made all the changes necessary. _____