

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. yes no, please list _____

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

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

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?
 yes no, explain _____

Women

Are you pregnant? yes no, 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. _____

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