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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 care for you.

x = Yes or No

HAVE YOU RECEIVED THE COVID-19 VACCINE? ❑ YES ❑ NO

1 ABOUT YOU

Today's date:_____ E-Mail address:_____
Name:_____
I prefer to be called:_____ ❑ Male ❑ Female
Birth date___/____/____ Age:_____ SS #:_____
Home address:_____
_____
❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated
Home #: (____)_____ Cell #: (___) _____
Work #: (____)_____ Ext.___ Direct #: (____)_____
Employer:_____
Employer's address:_____
How long there?: ____ Occupation:_____
Where & when are the best times to reach you?:_____
Whom may we thank for referring you?:_____
Other family members seen by us?:_____
Previous/Present dentist:_____
Last visit date?:_____

2 SPOUSE INFO

His/Her name:_____
Employer:_____
Work #: (___)_____ Ext.___ Direct #: (___)_____
Birth date____/_____/_____ SS #_____
Person responsible for account:_____
Work #: (___)_____ Ext.___ Direct #: (___)_____
Billing address: _____
Relationship: _____ SS #: _____
Employer: _____ Direct #: (___)_____

3 INSURANCE

Medical coverage?: ❑ Yes ❑ No Dental coverage?: ❑ Yes ❑ No
Insurance Co.: _____
Insurance Co. address: _____
Insurance Co. Phone #: (___) _____
Group #: (plan, local or policy #) _____
Insured's Name: _____ Relation: _____
Insured's Birth date___/____/____ Insured's SS#:_____
Insured's employer: _____
Insured's address: _____
Employer's address: _____

SECONDARY INSURANCE

Medical coverage?: ❑ Yes ❑ No Dental coverage?: ❑ Yes ❑ No
Insurance Co.: _____
Insurance Co. address: _____
Insurance Co. Phone #: (___) _____
Group #: (plan, local or policy #) _____
Insured's Name: _____ Relation: _____
Insured's Birth date___/____/____ Insured's SS#:_____
Insured's employer: _____
Insured's address: _____
Employer's address: _____

NEIGHBOR OR RELATIVE NOT LIVING WITH YOU.

His/Her name: _____ Relation: _____
Work #: (___)_____ Home #: (___)_____
Address:_____
_____

4 MEDICAL HISTORY

Do you have a Primary care physician? ❑ Yes ❑ No
Physician's name: _____
Phone #: (____) _____ Date of last visit?: _____

4 MEDICAL HISTORY

YOUR CURRENT PHYSICAL HEALTH IS: ❑ Good ❑ Fair ❑ Poor

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

Explain: _____

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

Have you had any metal rods, pins, or implants?: ❑ Yes ❑ No

Are you taking any prescription/over the counter drugs?: ❑ Yes ❑ No

Please list each: _____

FOR WOMAN: Are you taking birth control?: ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No Number of weeks#: _____

Are you nursing? ❑ Yes ❑ No

HAVE YOU EVER HAD ANY OF THE FOLLOWING:

Abdominal bleeding	❑ Yes ❑ No	Hemophilia	❑ Yes ❑ No
Alcohol/Drug abuse	❑ Yes ❑ No	Herpes/Fever blisters	❑ Yes ❑ No
Anemia	❑ Yes ❑ No	High blood pressure	❑ Yes ❑ No
Anxiety/Depression	❑ Yes ❑ No	High blood pressure	❑ Yes ❑ No
Arthritis	❑ Yes ❑ No	HIV+/AIDS	❑ Yes ❑ No
Artificial bones/joints/valves	❑ Yes ❑ No	Hospitalization	❑ Yes ❑ No
Asthma	❑ Yes ❑ No	Kidney problems	❑ Yes ❑ No
Blood transfusion	❑ Yes ❑ No	Liver disease	❑ Yes ❑ No
Cancer/Chemo.	❑ Yes ❑ No	Low blood pressure	❑ Yes ❑ No
Colitis	❑ Yes ❑ No	Mitral valve prolapse	❑ Yes ❑ No
Congenital heart defect	❑ Yes ❑ No	Pacemaker	❑ Yes ❑ No
Diabetes	❑ Yes ❑ No	Radiation treatment	❑ Yes ❑ No
Difficulty breathing	❑ Yes ❑ No	Rheumatic/scarlet fever	❑ Yes ❑ No
Emphysema	❑ Yes ❑ No	Seizures	❑ Yes ❑ No
Epilepsy	❑ Yes ❑ No	Shingles	❑ Yes ❑ No
Fainting spells	❑ Yes ❑ No	Sickle cell/traits	❑ Yes ❑ No
Frequent headaches	❑ Yes ❑ No	Sinus problems	❑ Yes ❑ No
Glaucoma	❑ Yes ❑ No	Stroke	❑ Yes ❑ No
Hay fever	❑ Yes ❑ No	Thyroid problems	❑ Yes ❑ No
Heart attack	❑ Yes ❑ No	Tuberculosis	❑ Yes ❑ No
Heart murmur	❑ Yes ❑ No	Ulcers	❑ Yes ❑ No
Heart surgery	❑ Yes ❑ No	Venereal disease	❑ Yes ❑ No

Please list any serious medical condition(s) that you have ever had:

_____

_____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING:

Aspirin ❑ Yes ❑ No **Erythromycin** ❑ Yes ❑ No **Tetracycline** ❑ Yes ❑ No

Codine ❑ Yes ❑ No **Latex** ❑ Yes ❑ No **Other** ❑ Yes ❑ No

Dental anesthetics ❑ Yes ❑ No **Penicillin** ❑ Yes ❑ No

Please list any drugs/materials that you are allergic to: _____

_____

4 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

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

Do you like your smile? ❑ Yes ❑ No Do your gums ever bleed? ❑ Yes ❑ No

How many times a week do you floss?_____ a day do you brush? _____

Type of bristles? ❑ Soft ❑ Medium ❑ Hard

How long do you use a toothbrush before replacing it? _____

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

Have you lost any teeth? ❑ Yes ❑ No If yes, why? _____

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 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

OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herin. Initials _____ Date _____

DOCTOR'S COMMENTS: _____

_____

_____