Welcome

Today's Date: _____

ABOUT YOU

Name: _____

(O) Male (O) Female I prefer to be called: _____

(O) Single (O) Married (O) Divorced (O) Widowed (O) Separated

Birthdate: _____ SSN: _____ Driver's License: _____

Home Address: _____

City _____ State _____ Zip _____

E-Mail Address: _____

Home Phone Number:_____Pager-Car Number: _____

Work Phone Number:_____ Ext: _____

Where & when are the best times to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us:_____

Employer:_____

How long there? _____ Occupation: _____

Employer's Address (Street/PO Box):_____

City _____ State _____ Zip _____

PERSON RESPONSIBLE FOR ACCOUNT IF OTHER THAN YOURSELF

Name: _____Relation: _____

Work Phone Number:_____Home Phone Number: _____

Social Security Number: _____Driver's License Number: _____

Employer: _____ Work Phone Number:_____ Ext: _

Billing Address: _____

Street: _____

City _____ State _____ Zip _____

SPOUSE INFORMATION

His / Her Name: _____

Birthdate:_____SSN:_____Driver's License Number: _____

Employer: _____

Work Phone Number: _____ Ext: _____

INSURANCE INFORMATION

Primary Insurance ..... Dental Coverage? (◯) Yes (◯) No

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
- Have you ever experienced pain/discomfort in your jaw joint? (TMJ / TMD)? (◯) Yes (◯) No
- Your current dental health is (◯) Good (◯) Fair (◯) Poor
- Do you floss daily? (◯) Yes (◯) No
- Brush daily? (◯) Yes (◯) No
- Type of bristles on your toothbrush? (◯) Hard (◯) Medium (◯) Soft
- How long do you use a toothbrush before replacing it? _____
- Do you use anything in addition to your brush and floss? (◯) Yes (◯) No
  If yes, what? _____
- Would you like fresher breath? (◯) Yes (◯) No Whiter teeth? (◯) Yes (◯) No
- Do your gums ever bleed? (◯) Yes (◯) No Ever Itch? (◯) Yes (◯) No
- Have you ever had periodontal disease? (◯) Yes (◯) No
- Do you have mobility in your teeth? (◯) Yes (◯) No
- Are your teeth sensitive to heat, cold or anything else? (◯) Yes (◯) No
- Do you still have wisdom teeth? (◯) Yes (◯) No
  If yes, why? _____
- Previous / Present Dentist: _____ Last Visit Date: _____
- Why did you leave your previous dentist? _____
- What did you like most & least about any dentist you have seen? _____
- 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: _____

City _____ State _____ Zip _____

Phone Number: _____ Date of last visit: _____

- Your current physical health is: (◯) 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?

(◯) Yes (◯) No	Aspirin	(◯) Yes (◯) No	Latex
(◯) Yes (◯) No	Barbiturates	(◯) Yes (◯) No	Penicillin
(◯) Yes (◯) No	Codeine	(◯) Yes (◯) No	Sedatives
(◯) Yes (◯) No	Dental Anesthetics	(◯) Yes (◯) No	Sulfa Drugs
(◯) Yes (◯) No	Erythromycin	(◯) Yes (◯) No	Tetracycline
(◯) Yes (◯) No	Jewelry / Metals	(◯) Yes (◯) No	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 Number:_____ Are you nursing? (◯) Yes (◯) No

Are you taking any of the following?(Please Circle)

Y N Acetaminophen	Y N Blood Thinners	Y N Insulin/Diabetes Drugs
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/Cortison	

- Are you taking any prescription, over-the-counter drugs, herbal remedies, vitamins or minerals not listed above? (◯) Yes (◯) No

If yes, please list each one: _____

- Do you have or have you experienced the following?

Y N Heart Attack	Y N Hepatitis	Y N Kidney Disease
Y N Heart Surgery	Y N Anemia	Y N Liver Disease
Y N Congenital Heart Defect	Y N Sickle Cell Disease	Y N Thyroid Problems
Y N Heart Murmur	Y N Diabetes	Y N Lupus
Y N Mitral Valve Prolaps	Y N Asthma	Y N Tumor or Growth
Y N High/Low Blood Pressure	Y N Emphysema	Y N Chemotherapy
Y N Pacemaker	Y N Arthritis	Y N Radiation Therapy
Y N Artificial Heart Valves	Y N Tuberculosis	Y N Venereal Disease
Y N Blood Transfusion	Y N Ulcers	Y N HIV+/AIDS
Y N Rheumatic Fever	Y N Seizures	Y N Drug/Alcohol Abuse
Y N Stroke	Y N Sinus Problems	Y N Glaucoma
Y N Abnormal Bleeding	Y N Headaches	Y N Artificial Joints

Y N Hospitalization for any other reason

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

SUBMIT