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Welcome! Thank you for choosing our office for your dental needs. To help us meet all of your needs, please fill out this form as completely as possible. If you need help or have any questions, please ask. Thank you.

Today's Date _____

Patient Information (Confidential)

Last Name _____ First Name _____ MI _____ Age _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
Social Security Number _____ Birthday _____
Do You Prefer To Receive Calls At Home Cell Work Any
Marital Status Minor Single Married Divorced Separated Widowed
Employment Status Student Employed Not Employed Retired
Employer _____ City, State _____
Emergency Contact _____ Phone _____ Relationship _____

Insurance/Responsible Party Information

Insured/Responsible Party _____ Relationship _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
Social Security Number _____ Birthday _____
Employer _____ City, State _____
Insurance Company _____ Phone _____
Address _____ City _____ State _____ Zip _____
Member/Subscriber ID Number _____ Group Number _____

Referral Information

How did you hear about our office? Phonebook Post Card Newspaper Radio Other
If other, How? _____

Patient Health History

Physician _____ Office Phone _____ Last Exam _____

- | | | | | | |
|--|--------------------------|--------------------------|--|--------------------------|--------------------------|
| | YES | NO | 5. Are you allergic to or have you had any reaction to any of the following? | YES | NO |
| 1. Are you under medical treatment now? | <input type="checkbox"/> | <input type="checkbox"/> | Local Anesthetic..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been hospitalized for any surgical operation or serious illness?..... | <input type="checkbox"/> | <input type="checkbox"/> | Penicillin/Amoxicillin..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you taking any medications, including non-prescription medicines?..... | <input type="checkbox"/> | <input type="checkbox"/> | Sulfa Drugs..... | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, what are you taking? _____ | | | Barbiturates (e.g. codeine)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| _____ | | | Aspirin..... | <input type="checkbox"/> | <input type="checkbox"/> |
| _____ | | | Latex..... | <input type="checkbox"/> | <input type="checkbox"/> |
| _____ | | | Other _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you use tobacco?..... | <input type="checkbox"/> | <input type="checkbox"/> | 6. WOMEN ONLY: | YES | NO |
| | | | a) Are you pregnant or could you be pregnant?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | b) Are you nursing?..... | <input type="checkbox"/> | <input type="checkbox"/> |

7. Do you have or have you had any of the following?
- | | | | | | | | | |
|----------------------------|--------------------------|--------------------------|----------------------------------|--------------------------|--------------------------|-----------------------------|--------------------------|--------------------------|
| | YES | NO | | YES | NO | | YES | NO |
| High Blood Pressure..... | <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease or Heart Attack... | <input type="checkbox"/> | <input type="checkbox"/> | Stomach Trouble/Ulcers..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic Fever..... | <input type="checkbox"/> | <input type="checkbox"/> | Cardiac Pacemaker..... | <input type="checkbox"/> | <input type="checkbox"/> | Easily Winded..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Fainting/Seizures..... | <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur..... | <input type="checkbox"/> | <input type="checkbox"/> | Stroke..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma..... | <input type="checkbox"/> | <input type="checkbox"/> | Angina..... | <input type="checkbox"/> | <input type="checkbox"/> | Hay Fever/Allergies..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Low Blood Pressure..... | <input type="checkbox"/> | <input type="checkbox"/> | Anemia..... | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy/Convulsions..... | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema..... | <input type="checkbox"/> | <input type="checkbox"/> | Radiation Therapy..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Leukemia..... | <input type="checkbox"/> | <input type="checkbox"/> | Cancer..... | <input type="checkbox"/> | <input type="checkbox"/> | Recent Weight Loss..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes..... | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis..... | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney Disease..... | <input type="checkbox"/> | <input type="checkbox"/> | Joint Replacement or Implant... | <input type="checkbox"/> | <input type="checkbox"/> | Respiratory Disease..... | <input type="checkbox"/> | <input type="checkbox"/> |
| AIDS or HIV Infection..... | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis/Jaundice..... | <input type="checkbox"/> | <input type="checkbox"/> | Other _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid Problem..... | <input type="checkbox"/> | <input type="checkbox"/> | Sexually Transmitted Disease... | <input type="checkbox"/> | <input type="checkbox"/> | Other _____ | <input type="checkbox"/> | <input type="checkbox"/> |

Patient Dental History

Reason for today's visit: _____

Date of Last Exam: _____ Date of Last X-rays: _____ Former Dentist: _____

How often do you brush? _____ How often do you floss? _____

- | | | | |
|--|--|--|--|
| Please check any of the following that apply to you: | <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Prolonged bleeding following extractions |
| | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Pain on chewing or biting |
| | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Food collecting between teeth | <input type="checkbox"/> Sores or growths in your mouth |
| | <input type="checkbox"/> Orthodontic treatment | <input type="checkbox"/> Frequent headaches | Sensitivity to: <input type="checkbox"/> Hot <input type="checkbox"/> Cold <input type="checkbox"/> Sweets |

Authorization and Release

I certify that I have read and understand the above information, to the best of my knowledge. I have answered the above questions as accurately as possible. I understand that providing incorrect information can be dangerous to my health. I authorize Myersville Dental to release any information, including the diagnosis, and/or records of any treatment or examination rendered to my dependent or me during the period of such dental care, to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group any insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of myself or my dependents.

Signature of Patient _____ Date _____

(or Parent/Guardian, if minor)