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 can care for you.

1 ABOUT YOU

Today's Date: _____

E-Mail Address: _____

Name: _____
Last First Mi Mr Mrs Ms Dr

I prefer to be called: _____ Male Female

Birthdate: ___/___/___ Age: ____ SS#: _____

Home Address: _____
Apt/Condo #

_____
City State Zip

Single Married Divorced Widowed Separated

Hm #: (____)_____ Pager / Cell #: _____

Wk #: (____)_____ Ext: ____ DL #: _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

_____

Other family members seen by us: _____

_____
(Please Circle)

Last Visit Date: _____

2 SPOUSE INFORMATION

His / Her Name: _____

Employer: _____

Wk #: (____)_____ Ext: ____ SS #: _____

Birthdate: ___/___/___ DL #: _____

Person Responsible for Account: _____

Wk #: (____)_____ Ext: ____ Hm #: (____) _____

Billing Address: _____

Relationship: _____ SS #: _____

Employer: _____ DL # _____

3 INSURANCE

Primary Insurance

Dental Coverage? Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____)_____

Group # (Plan, Local or Policy #): _____

Name: _____ Relation: _____

Birthdate: ___/___/___ ID #: _____

Employer: _____

Address: _____

Secondary Insurance

Dental Coverage? Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____)_____

Group # (Plan, Local or Policy #): _____

Name: _____ Relation: _____

Birthdate: ___/___/___ ID #: _____

Employer: _____

Address: _____

Neighbor or Relative not living with you.

His / Her Name: _____ Relation: _____

Wk #: (____)_____ Hm #: (____)_____

Address: _____

_____
City State Zip

4 MEDICAL HISTORY

Do you have a personal physician? Yes No

Physician's Name: _____

Phone #: (____)_____ Date of last visit: _____

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

Please explain: _____

4 MEDICAL HISTORY CONTINUED

Your current physical health is: ☐ Good ☐ Fair ☐ **Poor**

Do you smoke or use tobacco in any other form? ☐ Yes ☐

Have you had any metal rods, pins or implants? ☐ Yes ☐

Are you taking any prescription / over-the-counter or herbal supplemental drugs? ☐ Yes ☐

Please list each one: ____________________

____

Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐

Have you ever taken Phen-Fen? ☐ Yes ☐

For Women: Are you using a prescribed method of birth control? ☐ Yes ☐

Are you pregnant? ☐ Yes ☐ ____________

Are you nursing? ☐ Yes ☐

Have you ever had any of the following diseases or medical problems

Y	Abnormal Bleeding	Y	Herpes / Fever Blisters
Y	Alcohol / Drug Abuse	Y	High Blood Pressure
Y	Anemia	Y	HIV+ / AIDS
Y	Arthritis	Y	Hospitalized for Any Reason
Y	Artificial Bones / Joints / Valves	Y	Kidney Problems
Y	Asthma	Y	Liver Disease
Y	Blood Transfusion	Y	Low Blood Pressure
Y	Cancer /Chemotherapy	Y	Lupus
Y	Colitis	Y	Mitral Valve Prolapse
Y	Congenital Heart Defect	Y	Osteoporosis / Paget's Disease
Y	Diabetes	Y	Pacemaker
Y	Difficulty Breathing	Y	Psychiatric Problems
Y	Emphysema	Y	Radiation Treatment
Y	Epilepsy	Y	Rheumatic / Scarlet Fever
Y	Fainting Spells	Y	Seizures
Y	Frequent Headaches	Y	Shingles
Y	Glaucoma	Y	Sickle Cell Disease / Traits
Y	Hay Fever	Y	Sinus Problems
Y	Heart Attack	Y	Stroke
Y	Heart Murmur	Y	Thyroid Problems
Y	Heart Surgery	Y	Tuberculosis (TB)
Y	Hemophilia	Y	Ulcers
Y	Hepatitis	Y	Venereal Disease

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

____

____

Are you allergic to any of the following?

Y	Aspirin	Y	Erythromycin	Y	Tetracycline
Y	Codeine	Y	Latex	Y	Other
Y	Dental Anesthetics	Y	Penicillin		

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

____

5 DENTAL HISTORY

[illegible] ____________

____

Do you require antibiotics before dental treatment? ☐ Yes ☐

Are you currently in pain? ☐ Yes ☐

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐

Have you ever had gum treatment? ☐ Yes ☐

[illegible] ☐ **Yes** ☐

Your current dental health is ☐ ☐ ☐ Poor

Do you like your smile? ☐ ☐ N Do your gums ever bleed? ☐ Y ☐

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

Type of bristles? ☐ ☐ 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 ☐ 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

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. Initials: ____________ Date: ____________

Doctor's Comments: ____________________

____

MEDICAL HISTORY UPDATE

I have read my medical history dated _______ and confirmed that it states past and present medical conditions. ____________
Signature Date

I have read my medical history dated _______ and confirmed that it states past and present medical conditions. ____________
Signature Date

I have read my medical history dated _______ and confirmed that it states past and present medical conditions. ____________
Signature Date

With recent advancements in materials and techniques, many of our patients are inquiring about cosmetic dental procedures. In order to better serve you, please take a moment to let us know how you feel about the appearance of your smile.

Name_____**Date**_____

	YES	or	NO
Do you like the appearance of your teeth?	○		○
Are your teeth as straight as you would like them to be?	○		○
Are you happy with the length, width, and shape of your teeth?	○		○
Do you think you have a "gummy" smile?	○		○
Do you have any chipped teeth?	○		○
Do you have any missing teeth?	○		○
Do you have any spaces between your teeth?	○		○
Do you have any discolorations, stains or spots on your teeth?	○		○
Would you like your teeth to be whiter?	○		○
Do you have any dental work that you do not like?	○		○
Do you have any silver fillings that you would like changed to white?	○		○
Do you know anyone that has any cosmetic dentistry that interests you?	○		○

From the above questions, which concerns you the most?

_____

_____

If you could change anything about the appearance of your teeth, what would it be?

_____

_____

Dr. Allan Fine, Dr. Joanne Young, and Dr. Ryan Schatz (661)259-7760