Welcome

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 #: (____)_____ Cell#: (____)_____

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

Employer: _____

Employer's Address: _____

How long there: _____ Occupation: _____

Where & when is it best to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____

Last Visit Date: _____

Spouse Information

His / Her Name: _____

Employer: _____

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

Birthdate: ___/___/___ DL #: _____

Person Responsible for Account: _____

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

Billing Address: _____

Relation: _____ SS #: _____

Empoyer: _____ DL #: _____

Insurance Coverage

Primary

Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____)_____

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

Insured's Name: _____ Relation: _____

Insured's Birthdate:___/___/___ Insured's ID #: _____

Insured's Employer: _____

Secondary

Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____)_____

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

Insured's Name: _____ Relation: _____

Insured's Birthdate:___/___/___ Insured's ID #: _____

Insured's Employer: _____

In the event of an emergency, is there someone who lives near you that we should contact?

His / Her Name: _____ Relation: _____

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

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:_____

Continued on Back

Medical History *continued*

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

Are you taking any prescription/over-the-counter or herbal supplement drugs? ☐ Yes ☐ No

Please list each one: _____

_____

Have you ever taken Fosamax or any other bisphosphonate? _____

Have you ever taken Phen-fen? ☐Yes ☐ No

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

Are you pregnant? ☐Yes ☐No Week #:_____

Are you nursing? ☐Yes ☐No

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

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

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

_____

_____

Are you allergic to any of the following?

Y	N	Aspirin	Y N	Erythromycin	Y N Metals
Y	N	Codeine	Y N	Jewelry	Y N Penicillin
Y	N	Dental Anesthetics	Y N	Latex	Y N Tetracycline

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

_____

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

Do your gums ever bleed? ☐Yes ☐ No

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

Would you like whiter teeth? ☐Yes ☐ No

Fresher breath? ☐Yes ☐ No

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

Type of bristles? ☐ Soft ☐ Medium ☐ Hard

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

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. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

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 and direct payment of the dental benefits otherwise payable to me, directly to Dr. Thomas E Cyr.

_____

Signature Date

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