

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 #: _____

Employer: _____ 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: _____

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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