WELCOME TO OUR OFFICE

We thank you in advance for filling out these forms.

Patient Information **Please Print**

Date_____ Birth Date_____ SS#_____

Name_____ Preferred Name_____

Address _____City _____State_____

Home Phone_____ Work Phone_____ Cell Phone _____

Email Address _____

☐ Male ☐ Female ☐ Married ☐ Single

Employer_____

Alternate Contact _____ Phone _____

Referring Dentist _____ Have we treated you in the past?____

Dental Insurance Information

Primary Insurance

Insured Name_____

Relationship to Patient ☐Self ☐Spouse ☐Child

Employee_____

Name of Insurance_____

Birth Date_____ Insurance ID#_____

Secondary Insurance

Insured Name_____

Relationship to Patient ☐Self ☐Spouse ☐Child

Employee_____

Name of Insurance_____

Birth Date_____ Insurance ID#_____

☐ Parent ☐ Spouse Information

Name_____ Birth Date _____Home Phone_____

Address if different from above:_____

Employer_____ Work Phone _____SS#_____

GENERAL HEALTH HISTORY

Name_____ Age_____

Physician's Name_____ Address _____

Are you in good general health? ☐ Yes ☐ No
Have you ever had uncontrollable bleeding? ☐ Yes ☐ No
Do you smoke? ☐ Yes ☐ No How much?_____ How long?_____
Are you allergic to any medication? ☐ Yes ☐ No List:_____
Are you taking any prescription or over the counter medications?
_____
Are you currently under a physician's care? ☐ Yes ☐ No
Do you have any condition requiring antibiotic premedication prior to dental treatment?
☐ Yes ☐ No Please describe:_____

HAVE YOU HAD? (Please check appropriate boxes)

☐ Asthma	☐ Anemia	☐ High Blood Pressure
☐ Tuberculosis	☐ Diabetes	☐ Rheumatic Fever
☐ Stomach Trouble	☐ Hepatitis	☐ Kidney Trouble
☐ Prosthetic Joint	☐ HIV	☐ Liver Trouble
☐ Thyroid Problem	☐ Allergies	☐ Heart Valve Damage
☐ Cancer	☐ Low Blood Pressure	☐ Mental Disorders

Other Health Conditions?_____

Women: Are you or could you be pregnant? ☐ Yes ☐ No
If yes, what trimester? _____
Are you breast feeding? ☐ Yes ☐ No
Are you taking oral contraceptives? ☐ Yes ☐ No
Use of antibiotics may cause decreased effectiveness of oral contraceptives.

Do you/or have you had?: (Please check appropriate boxes)

☐ Dental Pain	☐ Bleeding Gums	☐ Sores in the mouth
☐ Lumps in the mouth	☐ Persistent Earaches	☐ Persistent Headaches

Have you ever had Periodontal Treatment? When?_____ Where?_____
Would you be distressed to wear dentures? ☐ Yes ☐ No
Are you willing to make an effort to keep your teeth? ☐ Yes ☐ No

Office Policy and Treatment Consent

I hereby certify that the foregoing information is correct. I give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending periodontist or supervised staff for diagnostic purposes or dental treatment. I will be responsible for any financial obligations incurred for dental treatment.

Signature_____ Guardian_____Date_____