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 these forms completely. The better we communicate, the better we can care for you. We are committed to your oral health.

About You

Today's Date____________

Legal Name ____Mr. Mrs. Ms. Miss Dr.

Last First MI

I prefer to be called________________________________ Male Female

Birthdate / / Age____ SS#__________________ DL#_____________

Single Married Divorced Widowed Separated

Home Address ________________________________ Home #_________________

________________________________ Work #___________________

City ST Zipcode Cell # __________________

Email: ______________________________

Employer ____________________________ Employer's Address____________________

How Long?____________________________Occupation___________________________

Where and when are the best times to reach you?_________________________________

Whom may we thank for referring you?____

Others family members seen by us____

Previous dentist________________________ Last date of visit_____________________

Spouse's Name_________________________ Employer__________________________

Occupation____________________________Work #____________________________

Person Responsible for Account (if other than patient)

Billing Address________________________Home #____________Wk#____________

Employer________________________SS#____________________DL#____________

Relationship to the patient______________________

Dental Insurance

Insurance Company Name_______________________Address_____________________

Insurance Company Phone #_____________________ _____________________

Group #___________Policy #________________

Insured's Name_____________________Relationship___________Birthday__________

Insured SS#_______________________Insured's Employer______________________

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

Their Name_______________________Relationship_______________

Home #__________________________Work#__________________

(please turn over to complete the health history portion)

Medical History

Do you have a personal physician? Yes No
Physician's Name___________________
Phone #___________________________
Date of last visit___________________
Your current physicial health is
Good Fair Poor
Are you currently under the care of a Physician? Yes No
Please explain_____________________
Are you taking prescription drugs or over the counter drugs? Yes No
Please list each one_________________
____
Are you currently taking any herbal or vitamin supplements?
Please list each one _________________
____
Do you smoke cigarettes or use any other Tobacco products? _________________
For Women: Are you taking Birth Control Pills? Yes No
Are you pregnant? Yes No Week #_____
Are you nursing? Yes No

Please answer each question below by circling Y (yes) or N (no)

Y N Heart Attack/Stroke
Y N Heart Surgery
Y N Pacemaker
Y N Heart Murmur
Y N Mitral Valve Prolapse
Y N High Blood Pressure
Y N Low Blood Pressure
Y N Rheumatic Fever
Y N Congenital Heart Defect
Y N Artificial Valves
Y N Cancer/Chemo
Y N Radiation Treatment
Y N Hemophilia
Y N Abnormal Bleeding
Y N Blood Transfusion
Y N Anemia
Y N Arthritis
Y N Diabetes
Y N Artificial Joints
Y N Ulcers/Colitis
Y N Drug/Alcohol abuse
Y N Osteoporosis
Y N Fever Blisters
Y N Shingles
Y N Hepatitis
Y N TB
Y N Venereal Disease
Y N HIV+/Aids
Y N Headaches
Y N Sinus Problems
Y N Emphysema
Y N Asthma
Y N Kidney Problems
Y N Difficulty Breathing
Y N Sleep Apnea
Y N Psychiatric Problems
Y N Glaucoma
Y N Epilepsy/Seizures

Please list any serious medical condition(s) or hospitalizations that you have ever had___________
____
____

If you answered **Yes** to any of the above questions please give date of occurrence or diagnosis_________
____
____

Allergy Information

Are you allergic to any of the following?
Y N Penicillin
Y N Tetracycline
Y N Latex
Y N Aspirin
Y N Anesthesia (dental)
Y N Erythromycin
Y N Codeine
Y N Other (specify)
Y N Metals (specify)

Dental History

Why have you come to the dentist today?
____
Are you currently in pain? Yes No
Have you ever had a serious/difficult problem associated with any previous dental work? Y N
Do you now or have you ever experienced pain or discomfort in your jaw joint(TMJ)? Y N
Your current dental health is Good Fair Poor
Do you like your smile? Yes No
Do your gums ever bleed? Yes No
How many times a week do you floss? ____
How many times a day do you brush?_____
Type of bristles? Hard Medium Soft

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 of 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 service(s) with my informed consent that I may need during diagnosis and treatment.

____
Signature Date

Payment is due in full at the time of treatment unless prior arrangements have been approved.

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

************For office use**************
I reviewed the medical/dental information with the patient herein.
Staff Initials_________Date___________
Doctor's Comments____________________
____
Medical History Update:
1.Date______Comments_______________
2.Date______Comments_______________
3.Date______Comments_______________
4.Date______Comments_______________
5.Date______Comments_______________
6.Date______Comments_______________