WELCOME!

Please complete this form so that we may better care for you.

ABOUT YOU...

Name:_____
I prefer to be called_____
Birthdate:_____
[] Male [] Female Age_____
Social Security Number____-____-_____
Home Address_____
_____
Home Telephone #_____
Work Telephone #_____
Employer _____
Employer's Address_____
_____
How long have you been employed there?_____
Occupation _____
Whom may I thank for referring you?_____
Other family members seen at this office_____
_____
Previous dentist_____
Last dental treatment date(approx.)_____
PERSON RESPONSIBLE FOR YOUR ACCOUNT
[] Self [] Other _____

PRIMARY DENTAL INSURANCE...

Insurance Company Name:_____
Insurance Company Address_____
Insurance Company Telephone _____
Group Number (Plan, Local or Policy#)_____
Insured's Name (which family member carries the insurance?)_____
Social Security Number of Insured ____-____-_____
Relationship of Yourself to Insured_____
Insured's Birthday_____
Insured's Employer_____

SECONDARY DENTAL INSURANCE...

Insurance Company Name:_____
Insurance Company Address_____
Insurance Company Telephone #_____
Group Number (Plan, Local or Policy#)_____
Insured's Name (which family member carries the insurance?)_____
Social Security Number of Insured ____-____-_____
Relationship of Yourself to Insured_____
Insured's Birthday_____
Insured's Employer_____

ABOUT YOUR SPOUSE...

Name:_____
Birthdate:_____
[] Male [] Female Age_____
Social Security Number____-____-_____
Home Address(if different)_____
Home Telephone #_____
Work Telephone #_____
Employer _____
Employer's Address_____
_____

MEDICAL HISTORY

DO YOU HAVE A PERSONAL PHYSICIAN?
[]YES [] NO
Physician's Name_____
Physician's Address:_____
Physician's Phone #_____
Date of last exam_____

IN THE EVENT OF AN EMERGENCY, IS THERE SOMEONE TO CONTACT?_____
Telephone #_____ Relationship_____

Cell Telephone Number_____

Email Address_____

MEDICAL HISTORY

Your Current Physical Health is [ ] good [ ] fair [ ] poor
Are you currently under the care of a physician? [ ] yes [ ] no
If yes, for what condition are you being treated?_____

_____

_____

ARE YOU CURRENTLY TAKING ANY MEDICATIONS?
[ ] Yes [ ] No
IF YES, LIST ALL MEDICATIONS YOU ARE TAKING

_____

_____

FOR WOMEN ONLY:
Are you pregnant? [ ] Yes Week_____ [ ] No

ALLERGY HISTORY

Are you allergic to any of the following?

Y	N	Penicillin	Y	N	Tetracycline
Y	N	Erythromycin	Y	N	Aspirin
Y	N	Other Antibiotic	Y	N	Latex
Y	N	Dental Anesthetics	Y	N	Codeine
Y	N	OTHER _____			

_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

Y	N	Heart attack/stroke	Y	N	Psychiatric Problems
Y	N	Cancer/Chemotherapy	Y	N	Epilepsy/ Seizures
Y	N	Heart Murmur	Y	N	Fainting Spells
Y	N	Rheumatic Fever	Y	N	Diabetes
Y	N	Heart Surgery	Y	N	Tuberculosis
Y	N	Pacemaker	Y	N	Drug/alcohol abuse
Y	N	Mitral Valve Prolapse	Y	N	Venereal Disease
Y	N	Artificial Heart Valves	Y	N	Hemophilia
Y	N	High Blood Pressure	Y	N	Abnormal Bleeding
Y	N	Low Blood Pressure	Y	N	Ulcers / Colitis
Y	N	Congenital heart defect	Y	N	Anemia
Y	N	Blood Transfusion	Y	N	Radiation Treatments
Y	N	Shingles	Y	N	Asthma
Y	N	Kidney Problems	Y	N	Arthritis
Y	N	Artificial Joints	Y	N	Difficulty Breathing
Y	N	Sinus Problems	Y	N	Hepatitis
Y	N	Fever Blisters	Y	N	Emphysema
Y	N	Frequent Headaches	Y	N	Glaucoma
Y	N	HIV+/AIDS	Y	N	Dry Mouth

Please explain any YES answers to the above questions

_____

_____

_____

Is there any other medical condition not listed above that you may have?

_____

_____

DENTAL HISTORY

Why did you come to our office today? _____

_____

_____

Are you currently in pain? [ ] Yes [ ] No
Have you ever had a serious or difficult problem associated with any previous dental work?
[ ] Yes [ ]No Explain_____

_____

_____

Have you ever had pain or discomfort in your jaw joint? [ ] Yes [ ] No Explain_____

_____

Do you consider your present dental health as being
[ ] Good [ ] Fair [ ] Poor
Do you like your smile? [ ] Yes [ ] No
If you do not like your smile, what aspect are you concerned with? _____

_____

_____

Do your gums ever bleed? [ ] Yes [ ] No
How many time a week do you floss? _____
How many times a day do you brush? _____
What type of toothbrush bristles do you use?
[ ] Soft [ ] Medium [ ] Hard
Are there any other concerns you may have about your teeth? _____

_____

_____

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 confidence, and that it is my responsibility to inform this office of any changes in my medical condition. I authorize the staff of this office to perform any necessary dental treatment with my informed consent that I may need during diagnosis and treatment.

_____ _____

Signature Date