Welcome!

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About You

Today's Date: _____ Email Address: _____

Name: _____ I prefer to be called: _____

Birthdate: ____/____/____ Age: _____ Social Security #: _____ ❑ Male ❑ Female

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Address: street_____city_____zip_____

Home Phone: (_____)_____ Cell/Pager: (_____)_____ Work Phone: (_____)_____

Who may we thank for referring you? _____ Other family members seen by us? _____

Emergency Contact Information

Spouse Information

His/Her Name: _____ Birthdate: ____/____/____ Social Security #: _____

Employer: _____ Work Phone: (_____)_____

Neighbor or Relative not living with you

His/Her Name: _____ Relation: _____ Work Phone: (_____)_____ Home Phone: (_____)_____

Address: _____

Dental Insurance Information

Primary Dental Insurance:

Insurance Co. Name: _____ Phone #: (_____)_____ Group # (Plan, Local, or Policy #): _____

Insurance Co. Address: _____

Policy Owner's Name: _____ Relationship to Patient: _____

Policy Owner's Birthday: ____/____/____ Social Security #: _____

Employer's Name: _____

Secondary Dental Insurance:

Insurance Co. Name: _____ Phone #: (_____)_____ Group # (Plan, Local, or Policy #): _____

Insurance Co. Address: _____

Policy Owner's Name: _____ Relationship to Patient: _____

Policy Owner's Birthday: ____/____/____ Social Security #: _____

Employer's Name: _____

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Medical History

Do you have a personal Physician? ❑ Yes ❑ No
Physician's Name: _____ Phone: (___) _____ Last Visit date: _____
Address: _____

Your current physical health is: ❑ Good ❑ Fair ❑ Poor
Are you currently under the care of a physician? ❑ Yes ❑ No Please explain: _____
Do you smoke or use tobacco in any other form? ❑ Yes ❑ No _____

For Women: Are you taking birth control pills? ❑ Yes ❑ No
Are you pregnant? ❑ Yes ❑ No ❑ Unsure If yes, week #: _____
Are you nursing? ❑ Yes ❑ No

Do you or have you experienced the following?

- ❑ Abnormal Bleeding
- ❑ Alcohol Abuse
- ❑ Anemia
- ❑ Arthritis
- ❑ Artificial Bones/Joints
- ❑ Artificial Valves
- ❑ Asthma
- ❑ Blood Transfusion
- ❑ Cancer
- ❑ Chemotherapy
- ❑ Chicken Pox
- ❑ Colitis
- ❑ Congenital Heart Defect
- ❑ Diabetes
- ❑ Difficulty Breathing
- ❑ Drug Abuse
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Ever Hospitalized
- ❑ Fainting Spells
- ❑ Fever Blisters
- ❑ Glaucoma
- ❑ Hay Fever
- ❑ Headaches
- ❑ Heart Attack
- ❑ Heart Murmur
- ❑ Heart Surgery
- ❑ Hemophilia
- ❑ Hepatitis
- ❑ Herpes
- ❑ High Blood Pressure
- ❑ HIV+/AIDS
- ❑ Kidney Problems
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Lupus
- ❑ Mitral Valve Prolapse
- ❑ Pacemaker
- ❑ Persistent Cough
- ❑ Psychiatric Problems
- ❑ Radiation Treatment
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Seizures
- ❑ Shingles
- ❑ Sickle Cell Anemia
- ❑ Sinus Problems
- ❑ Steroid Therapy
- ❑ Stroke
- ❑ Thyroid Problems
- ❑ Tonsillitis
- ❑ Tuberculosis (TB)
- ❑ Ulcers
- ❑ Venereal Disease

Please list any serious medical condition(s) that you have experienced: _____

Are you taking any prescription/over the counter drugs? ❑ Yes ❑ No If yes, please list _____

Do you require antibiotics before dental treatment? ❑ Yes ❑ No If yes, please explain _____

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Dental Anesthetics	Y	N	Latex	Y	N	Sulfa Drugs
Y	N	Barbiturates	Y	N	Erythromycin	Y	N	Penicillin	Y	N	Tetracycline
Y	N	Codeine	Y	N	Jewelry/Metals	Y	N	Sedatives	Y	N	Other

Please list anything additional that causes allergic reactions: _____

Dental History

Why have you come to the dentist today? _____

Y N Are you currently in pain?
Y N Do you brush daily?
Y N Do you floss daily?
Y N Do your gums ever bleed?
Y N Have you ever had periodontal disease?
Y N Do you have mobility in your teeth?
Y N Are you happy with the way your smile looks?

Your current dental health is: ❑ Good ❑ Fair ❑ Poor
Type of bristles on your toothbrush? ❑ Hard ❑ Medium ❑ Soft

Y N Are your teeth sensitive to heat, cold, or anything else?
Y N Do you still have wisdom teeth?

If not, what would you change? _____

(❑ Previous ❑ Present) Dentist: _____ Last Visit date: _____

Authorization

I affirm that the information that I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need. I assign the Doctor all insurance benefits. I also hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic. I understand that I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover.

_____ _____
Signature Date

For Office Use Only: