

# Melaine

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain optimal oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

## 1

### 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 ☐ Partnered ☐ Divorced/Separated ☐ Widowed

Hm #: (\_\_\_\_) \_\_\_\_\_ Cell / Other #: \_\_\_\_\_

Wk #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ DL #: \_\_\_\_\_

**Employer:** \_\_\_\_\_

Employer's Address: \_\_\_\_\_

\_\_\_\_\_  
City State Zip

How long there? \_\_\_\_\_ Occupation: \_\_\_\_\_

Where & when are best times to reach you? \_\_\_\_\_

**Whom may we Thank for referring you?** \_\_\_\_\_

Other family members seen by us: \_\_\_\_\_

**Previous / Present Dentist:** \_\_\_\_\_  
(Please Circle)

**Person Responsible for Account:** \_\_\_\_\_

## 2

### SPOUSE INFORMATION

His / Her Name: \_\_\_\_\_

Employer: \_\_\_\_\_

Wk #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ SS #: \_\_\_\_\_

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ DL #: \_\_\_\_\_

**Relative or Friend not living with you (for emergency).**

His / Her Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Wk #: (\_\_\_\_) \_\_\_\_\_ Hm #: (\_\_\_\_) \_\_\_\_\_

## 3

### INSURANCE

#### Primary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

\_\_\_\_\_  
City State Zip

Insurance Co. Phone #: (\_\_\_\_) \_\_\_\_\_

Group # (Plan, Local or Policy #): \_\_\_\_\_

**Insured's Name:** \_\_\_\_\_ **Relation:** \_\_\_\_\_

**Insured's Birthdate:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Insured's ID #:** \_\_\_\_\_

**Insured's Employer:** \_\_\_\_\_

**Employer's Address:** \_\_\_\_\_

\_\_\_\_\_  
City State Zip

#### Secondary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

\_\_\_\_\_  
City State Zip

Insurance Co. Phone #: (\_\_\_\_) \_\_\_\_\_

Group # (Plan, Local or Policy #): \_\_\_\_\_

**Insured's Name:** \_\_\_\_\_ **Relation:** \_\_\_\_\_

**Insured's Birthdate:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Insured's ID #:** \_\_\_\_\_

**Insured's Employer:** \_\_\_\_\_

**Employer's Address:** \_\_\_\_\_

\_\_\_\_\_  
City State Zip

**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 payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature \_\_\_\_\_ Date \_\_\_\_\_

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Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: \_\_\_\_\_

Phone #: (\_\_\_\_) \_\_\_\_\_ Date of last visit: \_\_\_\_\_

**Your current physical health is:** ☐ Good ☐ Fair ☐ PoorAre you currently under the care of a physician? ☐ Yes ☐ No

Please explain: \_\_\_\_\_

Do you smoke or use tobacco in any other form? ☐ Yes ☐ NoHave you been told that you snore or hold your breath while sleeping or wake up gasping for breath? ☐ Yes ☐ NoHave you had any metal rods, pins or implants? ☐ Yes ☐ NoAre you taking any prescription / over-the-counter drugs? ☐ Yes ☐ No

Please list each one: \_\_\_\_\_

Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No**For Women:** Are you using a prescribed method of birth control? ☐ Yes ☐ NoAre you pregnant? ☐ Yes ☐ No

Week #: \_\_\_\_\_

Are you nursing? ☐ Yes ☐ No**Have you ever had any of the following diseases or medical problems**

- |  |  |
|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Bleeding / Hemophilia     | <input type="checkbox"/> Y <input type="checkbox"/> N Herpes / Fever Blisters      |
| <input type="checkbox"/> Y <input type="checkbox"/> N AIDS                               | <input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure          |
| <input type="checkbox"/> Y <input type="checkbox"/> N Alcohol / Drug Abuse               | <input type="checkbox"/> Y <input type="checkbox"/> N HIV                          |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia                             | <input type="checkbox"/> Y <input type="checkbox"/> N Hospitalized for Any Reason  |
| <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis                          | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney Problems              |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial Bones / Joints / Valves | <input type="checkbox"/> Y <input type="checkbox"/> N Liver Disease                |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma                             | <input type="checkbox"/> Y <input type="checkbox"/> N Low Blood Pressure           |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood Transfusion                  | <input type="checkbox"/> Y <input type="checkbox"/> N Lupus                        |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer / Chemotherapy              | <input type="checkbox"/> Y <input type="checkbox"/> N Mitral Valve Prolapse        |
| <input type="checkbox"/> Y <input type="checkbox"/> N Colitis                            | <input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker                    |
| <input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Defect            | <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric Treatment        |
| <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes                           | <input type="checkbox"/> Y <input type="checkbox"/> N Radiation Treatment          |
| <input type="checkbox"/> Y <input type="checkbox"/> N Difficulty Breathing               | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic / Scarlet Fever    |
| <input type="checkbox"/> Y <input type="checkbox"/> N Emphysema                          | <input type="checkbox"/> Y <input type="checkbox"/> N Seizures                     |
| <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy                           | <input type="checkbox"/> Y <input type="checkbox"/> N Shingles                     |
| <input type="checkbox"/> Y <input type="checkbox"/> N Fainting Spells                    | <input type="checkbox"/> Y <input type="checkbox"/> N Sickle Cell Disease / Traits |
| <input type="checkbox"/> Y <input type="checkbox"/> N Frequent Headaches                 | <input type="checkbox"/> Y <input type="checkbox"/> N Sinus Problems               |
| <input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma                           | <input type="checkbox"/> Y <input type="checkbox"/> N Stroke                       |
| <input type="checkbox"/> Y <input type="checkbox"/> N Hay Fever                          | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid Problems             |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Attack / Surgery             | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis (TB)            |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur                       | <input type="checkbox"/> Y <input type="checkbox"/> N Ulcers                       |
| <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis                          | <input type="checkbox"/> Y <input type="checkbox"/> N Venereal Disease             |

Please list any serious medical condition(s) that you have ever had: \_\_\_\_\_

**Are you allergic to any of the following?**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Aspirin            | <input type="checkbox"/> Y <input type="checkbox"/> N Erythromycin   | <input type="checkbox"/> Y <input type="checkbox"/> N Penicillin   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Codeine            | <input type="checkbox"/> Y <input type="checkbox"/> N Jewelry/Metals | <input type="checkbox"/> Y <input type="checkbox"/> N Tetracycline |
| <input type="checkbox"/> Y <input type="checkbox"/> N Dental Anesthetics | <input type="checkbox"/> Y <input type="checkbox"/> N Latex          | <input type="checkbox"/> Y <input type="checkbox"/> N Other        |

Please list any other drugs/materials that you are allergic to: \_\_\_\_\_

**Why have you come to the dentist today?** \_\_\_\_\_Are you currently in pain? ☐ Yes ☐ NoDo you require antibiotics before dental treatment? ☐ Yes ☐ No**Your current dental health is:** ☐ Good ☐ Fair ☐ PoorHave you ever had a serious/difficult problem associated with any previous dental work? ☐ Yes ☐ NoDo you floss daily? ☐ Yes ☐ No Brush daily? ☐ Yes ☐ NoType of bristles on your toothbrush? ☐ Hard ☐ Medium ☐ SoftHave you ever had gum treatment? ☐ Yes ☐ NoDo your gums ever bleed? ☐ Yes ☐ No Ever Itch? ☐ Yes ☐ NoHave you ever had periodontal disease? ☐ Yes ☐ NoDo you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Are your teeth sensitive to heat, cold, or anything else? \_\_\_\_\_

Do you have any loose teeth? ☐ Yes ☐ NoDo you still have wisdom teeth? ☐ Yes ☐ NoWould you like fresher breath? ☐ Yes ☐ No Whiter teeth? ☐ Yes ☐ No**Are you happy with the way your smile looks?** ☐ Yes ☐ No

If not, what would you change? \_\_\_\_\_

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 \_\_\_\_\_

**OFFICE USE ONLY OFFICE USE ONLY**

I verbally reviewed the medical / dental information with the patient named herein.

Initials: \_\_\_\_\_ Date: \_\_\_\_\_

**Doctor's Comments:** \_\_\_\_\_

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

**MEDICAL HISTORY UPDATE**Has there been any change in your health status since your last visit? ☐ Y ☐ N  
If Yes, please explain. \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Dentist Signature \_\_\_\_\_ Date \_\_\_\_\_

Has there been any change in your health status since your last visit? ☐ Y ☐ N  
If Yes, please explain. \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Dentist Signature \_\_\_\_\_ Date \_\_\_\_\_