

WELCOME

Dr. Gregory Strickland

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

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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 Divorced Widowed Separated

Hm #: (____) _____ Pager / Cell #: _____

Wk #: (____) _____ Ext: _____

Employer: _____

Employer's Address: _____

Where & when are best time to reach you? _____

Whom may we Thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____
Please Circle

Last Visit Date: _____

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SPOUSE INFORMATION

His / Her Name: _____

Employer: _____

Wk #: (____) _____ Ext: ____ SS #: _____

Birthdate: ____ / ____ / ____ DL #: _____

Person Responsible for Account: _____

Wk #: (____) _____ Ext: ____ Hm #: (____) _____

Billing Address: _____

Relationship: _____ SS #: _____

Employer: _____ DL #: _____

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INSURANCE

Primary Insurance

Dental Coverage? Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____ / ____ / ____ Insured's SS#: _____

Insured's Employer: _____

Employer's Address: _____

Secondary Insurance

Dental Coverage? Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____ / ____ / ____ Insured's SS#: _____

Insured's Employer: _____

Employer's Address: _____

Neighbor or Relative not living with you.

His / Her Name: _____ Relation: _____

Wk #: (____) _____ Hm #: (____) _____

Address: _____

City

State

Zip

CONTINUED ON BACK

Do you have a personal physician? Yes No

Physician's Name: _____

Phone #: (____) _____ Date of last visit: _____

Are you currently under the care of a physician? Yes No

Please explain: _____

Your current physical health is: Good Fair Poor

Do you smoke or use tobacco in any form? Yes No

Are you taking any prescription / over-the-counter or herbal supplement drugs?
 Yes No

Please list each one: _____

For Women: Are you taking birth control pills? Yes No

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

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

Why have you come to the dentist today? _____

Do you require antibiotics before dental treatment? Yes No

Are you currently in pain? Yes No

Have you ever had a serious / difficult problem associated with any previous dental work? Yes No

Have you ever had gum treatment? Yes No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? Yes No

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? _____ a day do you brush? _____

Type of bristles? Soft Medium Hard

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

Have you lost any teeth? Yes No If yes, why? _____

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.

Signature _____

Date _____

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 _____

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.

I have read my medical history dated _____ and confirm that it states past & present medical conditions. _____
Signature _____ Date _____

I have read my medical history dated _____ and confirm that it states past & present medical conditions. _____
Signature _____ Date _____

I have read my medical history dated _____ and confirm that it states past & present medical conditions. _____
Signature _____ Date _____