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 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: _____ ☐ M ☐ F ☐ Non-binary

Birthdate: ___/___/___ Age: _____

Home Address: _____
APT / CONDO #

_____
CITY STATE ZIP

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

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

Wk #: (____) _____ Ext: ____

Employer: _____

Employer's Address: _____

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)

Last Visit Date: _____

2 Spouse Information

His / Her Name: _____

Employer: _____

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

Birthdate: ___/___/___ DL #: _____

Person Responsible for Account: _____

Contact #: (____) _____

Billing Address: _____

Relation: _____ SS #: _____

Employer: _____ DL #: _____

3 Dental Insurance

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

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

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

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

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

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

His / Her Name: _____ Relation: _____

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

4 Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Wk #: (____) _____ Date of last visit? _____

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

Please explain: _____

CONTINUED ON BACK

4 MEDICAL HISTORY continued

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you taking any prescription / over-the-counter or supplemental drugs? ☐ Yes ☐ No

Please list each one: _____

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

Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath? ☐ Yes ☐ No

For Women: Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #: _____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following disease or medical problems? (Please circle option that applies)

Y N	Anemia / Radiation Treatment	Y N	Heart Surgery / Pacemaker
Y N	Artificial Bones / Joints / Valves	Y N	Hemophilia / Abnormal Bleeding
Y N	Arthritis	Y N	Hepatitis
Y N	Asthma	Y N	High / Low Blood Pressure
Y N	Autism	Y N	HIV+ / AIDS
Y N	Blood Transfusion	Y N	Hospitalized for Any Reason
Y N	Cancer / Chemotherapy	Y N	Kidney Problems
Y N	Congenital Heart Defect	Y N	Mitral Valve Prolapse
Y N	Covid-19	Y N	Psychiatric Treatment
Y N	Diabetes	Y N	Rheumatic / Scarlet Fever
Y N	Difficulty Breathing	Y N	Severe / Frequent Headaches
Y N	Drug / Alcohol Abuse	Y N	Shingles
Y N	Emphysema / Glaucoma	Y N	Sickle Cell Disease / Traits
Y N	Epilepsy / Seizures / Fainting Spells	Y N	Sinus Problems
Y N	Fever Blisters / Herpes	Y N	Tuberculosis (TB)
Y N	Heart Attack / Stroke	Y N	Ulcers / Colitis
Y N	Heart Murmur	Y N	Venereal Disease

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

_____

Have you received vaccination for Covid-19? ☐ Yes ☐ No

Type? _____ Date(s)? _____

Are you allergic to any of the following?

Y N	Aspirin	Y N	Erythromycin	Y N	Penicillin
Y N	Codeine	Y N	Jewelry / Metals	Y N	Tetracycline
Y N	Dental Anesthetics	Y N	Latex	Y N	Other

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

_____

5 DENTAL HISTORY

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

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

Have you ever had periodontal disease? ☐ Yes ☐ No

How many times a week do you floss? _____ 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 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

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

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have questions at any time, please ask us. We are happy to help.

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

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I verbally reviewed the medical / dental information above with the patient named herein. Initials: _____ Date: _____

Doctor's Comments: _____

_____

MEDICAL HISTORY UPDATE

1. Date: _____ Comments: _____ Signature: _____

1. Date: _____ Comments: _____ Signature: _____

1. Date: _____ Comments: _____ Signature: _____

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