Welcome! *So that we may provide you with the best possible care, please complete both sides of this medical/dental history form. All information is completely confidential.*

1 About You

Today's Date: _____

Name: _____

I prefer to be called: _____ ❑ Male ❑ Female

Birthdate: __/__/__ Age: _____ SS#: _____

Home Address: _____

City _____ State _____ Zip _____

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Hm#: _____ Cell#: _____

Wk#: _____ Email: _____

Employer _____

Employer's Address: _____

How long there? _____ Occupation _____

Where & when are the best times to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

Previous/Present Dentist: _____

Last Visit Date: _____

3 Dental Insurance

Primary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address: _____

Insurance Co. Phone#: _____

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

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

Insured's Employer: _____

Secondary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address: _____

Insurance Co. Phone#: _____

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

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

Insured's Employer: _____

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

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

Please Explain: _____

Are you taking any prescription/ over-the-counter 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

2 Spouse Information

His/Her Name: _____

Employer: _____

Wk#: _____ Ext: _____ SS#: _____

Birthdate: __/__/__ Cell#: _____

Person Responsible for Account: _____

Wk#: _____ Ext: _____ Hm#: _____

Billing Address: _____

Relation: _____ SS#: _____

Employer: _____ Cell#: _____

4 Medical Information

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name _____

Phone #: _____ Last Visit Date: _____

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

His/Her Name: _____ Relation: _____

Wk#: _____ Hm#: _____

Are you allergic to any of the following?

Y N Aspirin Y N Erythromycin Y N Tetracycline

Y N Codeine Y N Latex Y N Other

Y N Dental Anesthetics Y N Penicillin

Please list any other drugs that you are allergic to:

_____

Have you ever had any of the following diseases or medical problems?

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

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

_____

_____

Dental History

Name: _____
Last First Middle

1. Any dental needs, discomfort, or requests at this time? _____
_____
2. When was your last dental examination? _____
3. When were x-rays last taken of **ALL** your teeth? _____
4. Do you use anything besides a brush for dental home care? _____
5. Anything interfering with regular dental care? Transportation? Anxiety? _____

Are any of your teeth sensitive to:

Hot or Cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get cold sores, blisters or any other oral lesions?	Yes	No

Do your gums bleed or hurt?

Have your parents experienced gum disease or tooth loss?	Yes	No
Have your noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught in-between your teeth?	Yes	No

If yes, where? _____

Do you:

Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Smoke/chew tobacco?	Yes	No

Have you ever had:

Orthodontic treatment?	Yes	No
Oral Surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No

If so, please describe, including cause _____
_____

Have you experienced:

Clicking or popping of the jaw?	Yes	No
Pain (joint, ear, side of face)	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Headaches, neck aches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No

Are you satisfied with your teeth's appearance?	Yes	No
Would you like to keep all of your teeth all of your life?	Yes	No
Do you feel nervous about having dental treatment?	Yes	No

If so, what is your biggest concern?
_____
_____

Have you ever had an upsetting dental experience? Yes No
If yes, please describe _____

Is there anything else about having dental treatment that you would like us to know? **Yes** **No**

If yes, please describe _____
_____

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.

Co payment/Payment is due in full at the time of treatment
Unless prior arrangement have been approved.

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.

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

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

Signature _____ Date _____

OFFICE USE ONLY OFFICE USE ONLY **OFFICE USE ONLY** OFFICE USE ONLY **OFFICE USE ONLY**

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

Doctor's comments: _____
_____