WELCOME

Please fill out this form completely. The better we communicate, the better we can serve you.

PLEASE BRING A COMPLETE LIST OF ALL MEDICATIONS (PRESCRIPTION & OVER THE COUNTER) YOU ARE CURRENTLY TAKING.

1. ABOUT YOU

Today's Date_____

Full Name _____

I prefer to be called_____ ( ) M ( ) F

Birth date ____/____/____ Age_____ SS# _____-___-_____

Home Address _____

_____

( ) Single ( ) Married ( ) Divorced ( ) Widowed ( ) Separated

Hm # _____ **Cell/Other**_____

Wk # _____ ext._____ DL#_____

E-MAIL _____

Employer_____

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 Dentist_____ Ph#_____

Last Visit Date_____ Last X-rays Date_____

2. Account Information

Person responsible for Account (if different than patient)_____

Hm # _____ Wk #_____ Cell#_____

Billing Address_____

_____

Relation to you_____ SS # _____-____-_____

Employer_____ DL #_____

3. DENTAL INSURANCE

PRIMARY DENTAL INSURANCE

Insured's Employer_____

Insurance Co. Name_____

Insurance Co. Address_____

_____

Insurance Co. Phone # _____

Group # (Plan, Local or Policy #) _____

Insured's Name_____Birth date ____/____/____

Relation to you_____ Insured's SS# _____-___-_____

SECONDARY DENTAL INSURANCE

WE NO LONGER FILE SECONDARY INSURANCE.

4. Medical Information

Do you have a personal physician? Yes No

Physician's Name_____

Address_____

Phone # _____ Last Visit Date ____/_____/____

Who to call in case of emergency _____

Hm # _____ Wk #_____ Cell#_____

Relation to you_____

5. Medical History

Your current physical health is ( ) Good ( ) Fair ( ) Poor

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

If yes, please explain_____

Please list all prescription / over-the-counter medications that you are currently taking_____

_____

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

Are you pregnant? ( ) Yes ( ) No Week #_____

Are you nursing? ( ) Yes ( ) No

Circle any medical conditions that you have or have had:

Alcohol/ Drug Abuse
Anemia
Arthritis: Osteo /Rheumatoid
Asthma
Autoimmune Disease: Type_____
Bleeding: Abnormal /Prolonged
Blood Disease: *Clotting Factor/ Sickle Cell/ Hemophilia*
Blood Transfusion: Date_____
Cancer: Chemotherapy/ Radiation
Congenital Heart Defect: *Repaired? Y N*
Diabetes: Type____
Endocarditis
Epilepsy
Fainting Tendency
Frequent Headaches
Glaucoma
Heart Trouble: *Attack/ Arrhythmia/Surgery: Date*_____
High Blood Pressure
GERD/ Ulcer/ Reflux
HIV+ / AIDS
Joint Replacement
Kidney/Bladder Problems: *stones*
Liver Disease: *Hepatitis Jaundice*
Low Blood Pressure
LUNG:*Emphysema COPD/Chronic Bronchitis*
Mitral Valve Prolapse
Osteoporosis
Pacemaker/Defibulator
Psychiatric Problems *Depression/Anxiety*
Rheumatic Fever
Seizures
Shingles
Sinus Problems
Stroke
Thyroid Problems
Tuberculosis (TB)
Venereal Disease

Please list any OTHER medical conditions that you have ever had_____

_____

Do you use any form of tobacco? ( ) Yes ( ) No

Do you drink beverages containing alcohol? ( ) Yes ( ) No

If so, _____# drinks per: day / week / month

Please circle if you are allergic to any of the following:

Aspirin
Codeine
Dental Anesthetic
Erythromycin
Latex
Penicillin
Tetracycline
Other

Please list any OTHER medications/food that you are allergic to_____

6. Dental History

Why have you come to the dentist today?

_____

_____

Do you need to be premedicated with 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 or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD/Grinding/Clenching)? ( ) Yes ( ) No

Your current dental health is ( ) Good Fair ( ) Poor

Do you floss daily? ( ) Yes ( ) No **Brush Daily?** ( ) Yes ( ) No

Type of Bristles on your toothbrush? ( ) Hard ( ) Medium ( ) Soft
How long do you use your toothbrush before replacing it?_____

Do you use anything in addition to your brush and floss?

If yes, what ?_____

Do your gums ever bleed? ( ) Yes ( ) No
Have you ever had periodontal disease? ( ) Yes ( ) No
Do you have mobility in your teeth? ( ) Yes ( ) No
Does food get caught between your teeth? ( ) Yes ( ) No

Are your teeth sensitive to heat or cold? ( ) Yes ( ) No
Are your teeth sensitive to sweets? ( ) Yes ( ) No
Are your teeth sensitive to chewing / biting? ( ) Yes ( ) No

Do you still have your wisdom teeth? ( ) Yes ( ) No

Have you lost any teeth? ( ) Yes ( ) No

If yes, how?_____

Have you had orthodontic treatment? ( ) Yes ( ) No

If yes, when?_____

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.

_____

Signature **Date**