WELCOME

We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health.

Patient Information

Today's Date: _____

Patient Name: _____

I prefer to be called: _____

Home phone: _____

Cell phone: _____

E-mail: _____

Home address: _____

City: _____ State: _____ Zip: _____

Date of birth: _____

SS #: _____ Male_____ Female _____

Single_____ Married_____

Spouse's name: _____

Your employer: _____

Occupation: _____

Work phone: _____

Work address: _____

City: _____ State: _____ Zip: _____

Best time **and** place to reach you? _____

Preferred appointment days: M T W TH F AM/PM

Are you available for short notice appointments? . . . . . Y N

Billing address (if different): _____

City: _____ State: _____ Zip: _____

Who may we thank for referring you? _____

_____

Primary Dental Insurance:

Do you have dental insurance? . . . . . Y N

Primary dental insurance: _____

Subscriber's name: _____

Employer: _____

Subscriber's date of birth: _____ SS #: _____

Subscriber's ID# or SS#: _____

Insurance Address: _____

City: _____ State: _____ Zip: _____

Is this insurance new to you? _____

Secondary Dental Insurance:

Do you have Secondary dental insurance? . . . . . Y N

Secondary dental insurance: _____

Subscriber's name: _____

Subscriber's employer: _____

Subscriber's date of birth: _____

Subscribers ID# or SS#: _____

Address: _____

City: _____ State: _____ Zip: _____

This coverage is through: Spouse ____Parent____ Other_____

Two Emergency Contacts (other than spouse)

Name: _____ Phone #: _____ Relationship: _____

Name: _____ Phone #: _____ Relationship: _____

Dental History

Previous Dentist: _____ Last visit: _____
Phone #: _____ City: _____

Are you apprehensive about dental treatment? . . . . . Y N
Do your gums bleed when you floss or brush? . . . . . Y N
Have you noticed slow-healing sores in your mouth? . . . . . Y N
Are you dissatisfied with the appearance of your teeth? . . . . . Y N
Do you experience any jaw discomfort? . . . . . Y N

Do you take fluoride supplements? . . . . . Y N
Have you ever had orthodontics (braces)? . . . Y N
Do you wear dentures/partials? . . . . . Y N
Are your teeth sensitive to hot or cold? . . . . . Y N
Do you clench or grind your teeth? . . . . . Y N
Do you use tobacco? . . . . . Y N
If yes, how often? _____

Medical History

Do you require antibiotics prior to dental treatment? . . . Y N
If yes, please explain: _____
_____

Have you ever been hospitalized? . . . . . Y N
If yes, please explain: _____
_____

Do you have a personal physician? . . . . . Y N
His/her name: _____
Phone #: _____

Are you currently under the care of ANY physician? . . . . . Y N
If yes, please explain: _____

Your current health is: Good _____ Fair _____ Poor _____

Please check if you have or had any of the following?

- ☐ AIDS/HIV positive
- ☐ Angina
- ☐ Drug addictions
- ☐ Heart attack/failure
- ☐ High/low blood pressure
- ☐ Lung disease
- ☐ Pacemaker
- ☐ Shingles
- ☐ Surgery _____
- ☐ **None of the above**
- ☐ Anemia
- ☐ Cancer
- ☐ Seizures/convulsions
- ☐ Heart murmur
- ☐ Kidney disease
- ☐ Mitral valve prolapsed
- ☐ Radiation treatment
- ☐ Sinus trouble
- ☐ STD
- ☐ Joint replacement _____
- ☐ Chemotherapy
- ☐ Excessive bleeding
- ☐ Hepatitis A
- ☐ Leukemia
- ☐ MRSA
- ☐ Rheumatic fever
- ☐ Stomach/intestinal disease
- ☐ Thyroid disease
- ☐ Artificial valves
- ☐ Diabetes
- ☐ Frequent headaches
- ☐ Hepatitis B or C
- ☐ Liver disease
- ☐ Psychiatric care
- ☐ Scarlet fever
- ☐ Stroke
- ☐ Tuberculosis

Please list all other medical conditions:

_____
_____
_____
_____

Please list all current medications (prescribed or over the counter):

_____
_____
_____
_____

Are you allergic to any of the following?

Local anesthetics ("Novocain") . . . . . Y N
Penicillin or other antibiotics . . . . . Y N
Sulfa drugs . . . . . Y N
Barbiturates, sedatives, or sleeping pills. . . . . Y N
Aspirin, Acetaminophen, or Ibuprofen. . . . . Y N
Codeine, Demerol, or other narcotics. . . . . Y N
Reaction to metals . . . . . Y N
Latex or rubber dam . . . . . Y N
Other: _____
_____

Women

Are you taking contraceptives or other hormones? . . . . . Y N
Are you pregnant? . . . . . Y N
If so, expected delivery date: _____
Are you nursing? . . . . . Y N

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.

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