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 Patient Information

Date:_______/_______/_______

Name: ____
LAST FIRST MI

I prefer to be called: ______________________ ❑ Male ❑ Female

Birthdate:______/______/______ Age:______ SS #:______-______-______

Home Address: ____

____
CITY STATE ZIP

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Home Phone:_______-_______-_______ Cell:______-______-______

Work Phone:________-________-________ Ext.: ______________

Employer: ____

Address: ____

Occupation: ____

Best place & time to reach you: ______________________________

Contact in Emergency: ______________________________

Relation: ____

Wk#:_______/_______/_______ Hm#:_______/_______/_______

Whom may we Thank for referring you?______________________

Previous Dentist: ______________________________

Last Visit There:______________________________

2 Spouse/Parent Information

Name: ____

Employer: ____

Work Phone:________-________-________ Ext.: ______________

Birthdate:_______/_______/_______ SS #:________-________-________

3 Responsible Party

Name: ____

Relation: ____

Billing Address:______________________________

____
CITY STATE ZIP

Employer: ____

Hm#:_______/_______/_______ Wk#:_______/_______/_______

SS #:___________-___________-___________ ___________

4 Insurance Coverage

Primary Dental Insurance

Name ____

Address ____

____
CITY STATE ZIP

Phone______/______/______Group/Plan# ______________

Insured's Name ______________________________

Relation ______________________Birthdate_____/_____/_____

SS#_____/_____/_____ Employer ______________

Secondary Dental Insurance

Name ____

Address ____

____
CITY STATE ZIP

Phone______/______/______Group/Plan# ______________

Insured's Name ______________________________

Relation ______________________ Birthdate_____/_____/_____

SS#_____/_____/_____ Employer ______________

5 Medical History

Personal Physician ______________________________

Phone______/______/______

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

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

Please Explain: ______________________________

____

Presently taking prescription/over the counter drugs? ❑ Yes ❑ No

Please list each one: ______________________________

____

____

Smoke or use tobacco in any form? ❑ Yes ❑ No

Women: Birth Control Pills? ❑ Yes ❑ No Pregnant? ❑ Yes ❑ No

Week # ______________ Nursing? ❑ Yes ❑ No

Y N Abnormal Bleeding
Y N Alcohol/Drug Abuse
Y N Anemia
Y N Arthritis
Y N Artificial Bones/Joints/Valves
Y N Asthma
Y N Blood Transfusion
Y N Cancer/Chemotherapy
Y N Colitis
Y N Congenital Heart Defect
Y N Diabetes
Y N Psychiatric Problems
Y N Breathing Difficulty
Y N Emphysema
Y N Epilepsy
Y N Fainting Spells
Y N Frequent Headaches
Y N Glaucoma
Y N Hay Fever
Y N Heart Attack
Y N Heart Murmur
Y N Heart Surgery
Y N Do you have any artificial joints?
Y N Hemophilia
Y N Hepatitis
Y N Herpes/Fever Blisters
Y N High Blood Pressure
Y N HIV+/Aids
Y N Hospitalized
Y N Kidney Problems
Y N Liver Disease
Y N Low Blood Pressure
Y N Mitral Valve Prolapse
Y N Pacemaker
Y N Radiation Treatment
Y N Rheumatic/Scarlet Fever
Y N Seizures
Y N Shingles
Y N Sickle Cell Disease/Traits
Y N Sinus Problems
Y N Stroke
Y N Thyroid Problems
Y N Tuberculosis (TB)
Y N Ulcers
Y N Venereal Disease

Are you allergic to any of the following?

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

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

____

____

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

____

____

6 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 treatment? ❑ Yes ❑ No

7

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.

!

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.

Signature______________________ Date __________

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

Office Use Only **Office Use Only** **Office Use Only**

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

Doctor's Comments ______________________________

____

1. Date __________ Comments: ______________________ Signature: __________

2. Date __________ Comments: ______________________ Signature: __________

3. Date __________ Comments: ______________________ Signature: __________