Welcome

Please fill out this form completely, it is important to your dental care.

ABOUT YOU

Today's Date: _____ Status: ☐ Married ☐ Single ☐ Partnered ☐ Divorced ☐ Separated ☐ Widowed

Name: _____ (LAST / FIRST / MI) ☐ M ☐ F Birthdate: ___/___/___ Age: _____ SS #: _____

Home Address: _____ (CITY / STATE / ZIP)

Hm #: (_____) _____ Cell #: (_____) _____ Wk #: (_____) _____ DL #: _____

E-Mail Address: _____ When are the best times to reach you? _____

Employer: _____ How long there? _____ Occupation: _____

Employer's Address: _____ (CITY / STATE / ZIP)

General Dentist: _____ Previous or Present (Please circle) Date of last visit: _____

Referring Dentist: _____

In the event of an emergency, whom should we contact?

His/Her Name: _____ Relation: _____ Wk #: (_____) _____

Hm #: (_____) _____ Address: _____ (CITY / STATE / ZIP)

SPOUSE INFORMATION

His/Her Name: _____ Birthdate: ___/___/___ SS #: _____

Employer: _____ Wk #: (_____) _____ DL #: _____

Person Responsible for Account, if other than yourself

Name: _____ Relation: _____ SS #: _____

Employer: _____ Wk #: (_____) _____ DL #: _____

Hm #: (_____) _____ Billing Address: _____

DENTAL INSURANCE INFORMATION

Primary Insurance

Insurance Co. Name: _____ Group # (Plan, Local or Policy #): _____ Member ID #: _____

Ins. Co. Ph #: (_____) _____ Ins. Co. Address: _____ (CITY / STATE / ZIP)

Insured's Name: _____ Relation: _____ Insured's Birthdate: ___/___/___ SS #: _____

Insured's Employer: _____

Secondary Insurance

Insurance Co. Name: _____ Group # (Plan, Local or Policy #): _____ Member ID #: _____

Ins. Co. Ph #: (_____) _____ Ins. Co. Address: _____ (CITY / STATE / ZIP)

Insured's Name: _____ Relation: _____ Insured's Birthdate: ___/___/___ SS #: _____

Insured's Employer: _____

HISTORY

Why have you been referred to our office? _____

_____

Are you currently in pain? ☐ Y ☐ N

Do you require antibiotics before dental treatment? ☐ Y ☐ N

Have you experienced problems associated with any previous dental work? ☐ Y ☐ N

Do you now or have you ever experienced pain / discomfort in your jaw (TMJ / TMD)? ☐ Y ☐ N

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

Do you floss daily? ☐ Y ☐ N Do you brush daily? ☐ Y ☐ N

Type of bristles on toothbrush: ☐ Hard ☐ Medium ☐ Soft

How often do you replace your toothbrush? _____

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

If yes, what? _____

Would you like fresher breath? ☐ Y ☐ N Whiter teeth? ☐ Y ☐ N

Do your gums bleed? ☐ Y ☐ N Do gums itch? ☐ Y ☐ N

Have you ever had periodontal disease? ☐ Y ☐ N

Do you have mobility in your teeth? ☐ Y ☐ N

Are your teeth sensitive to heat, cold or anything else? _____

Do you still have wisdom teeth? ☐ Y ☐ N

If yes, why? _____

Are you happy with the way your smile looks? ☐ Y ☐ N

If not, what would you change? _____

Do you have a personal physician? ☐ Y ☐ N

Physician's Name: _____

Address: _____

Phone #: (_____) _____ Date of last visit: _____

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

Are you currently under the care of a physician? ☐ Y ☐ N

Please explain: _____

Do you smoke or use tobacco in any form? ☐ Y ☐ N

Do you use controlled substances? ☐ Y ☐ N

Are you allergic to any of the following?

Y N Aspirin	Y N Erythromycin	Y N Penicillin
Y N Barbiturates	Y N Iodine	Y N Sedatives
Y N Codeine	Y N Jewelry / Metals	Y N Sulfa Drugs
Y N Dental Anesthetics	Y N Latex	Y N Tetracycline
		Y N Other

Please list additional drugs / materials that cause allergic reactions:

_____

Are you taking any of the following?

Y N Acetaminophen	Y N Blood Pressure Medication	Y N Recreational Drugs
Y N Antibiotics	Y N Cold Remedies	Y N Steroids / Cortisone
Y N Antihistamines	Y N Digitalis / Heart Medication	Y N Thyroid Medicine
Y N Aspirin	Y N Insulin / Diabetes Drugs	Y N Tranquilizers
Y N Blood Thinners	Y N Nitroglycerin	

Have you ever taken Phen-Fen (Redux or Pondimin)? ☐ Y ☐ N

Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? ☐ Y ☐ N

Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours? ☐ Y ☐ N

Are you currently taking any prescription, over-the-counter drugs, herbal remedies, vitamins or minerals not listed above? ☐ Y ☐ N

If yes, please list each one _____

Do you wear contact lenses? ☐ Y ☐ N

WOMEN: Are you taking birth control pills? ☐ Y ☐ N

Are you pregnant? ☐ Unsure ☐ Y ☐ N Week # _____

Are you nursing? ☐ Y ☐ N

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

Y N Abnormal Bleeding	Y N Congenital Heart Defect	Y N Heart Murmur	Y N Liver Disease	Y N Seizures
Y N Alcohol Abuse	Y N Diabetes	Y N Heart Surgery	Y N Low Blood Pressure	Y N Shingles
Y N Anemia	Y N Difficulty Breathing	Y N Hemophilia	Y N Lupus	Y N Sickle Cell Disease
Y N Arthritis	Y N Drug Abuse	Y N Hepatitis A (infectious)	Y N Mitral Valve Prolapse	Y N Sinus Problems
Y N Artificial Bones / Joints	Y N Emphysema	Y N Hepatitis B (serum)	Y N Osteoporosis	Y N Steroid Therapy
Y N Artificial Valves	Y N Epilepsy	Y N Herpes	Y N Pacemaker	Y N Stroke
Y N Asthma	Y N Fainting Spells	Y N High Blood Pressure	Y N Persistent Cough	Y N Thyroid Problems
Y N Blood Transfusion	Y N Fever Blisters	Y N HIV+ / AIDS	Y N Psychiatric Problems	Y N Tonsillitis
Y N Cancer	Y N Glaucoma	Y N Hospitalized for Any reason	Y N Radiation Treatment	Y N Tuberculosis (TB)
Y N Chemotherapy	Y N Hay Fever	Y N Hypoglycemia	Y N Rheumatic Fever	Y N Ulcers
Y N Chicken Pox	Y N Headaches	Y N Kidney Problems	Y N Scarlet Fever	Y N Venereal Disease
Y N Colitis	Y N Heart Attack			

AUTHORIZATIONS

I affirm that the information I have given is correct to the best of my knowledge. It 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 the necessary dental services I may need.

My method of payment will be _____.

_____ _____

SIGNATURE DATE

PAYMENT IS DUE AT TIME OF SERVICE.

I certify that I am covered by _____ Insurance Co.

and I assign directly to Dr. _____ all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____ _____

SIGNATURE DATE

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