Welcome to our office

HAL N. ARNOLD, D.M.D., M.S. | ESTHETIC & IMPLANT DENTISTRY
Diplomate, American Board of Prosthodontics

ABOUT YOU

Today's Date:_____

Name: _____

I prefer to be called:_____

Home Address: _____

_____

Home Phone: (____)_____

Work Phone: (____)_____Ext:_____

Email Address: _____

Social Security Number: _____

Birthdate: _____

Single Married Divorced Widowed Separated

Male Female

Whom may we thank for referring you? _____

Previous/Present Dentist: _____

Last Visit Date: _____

Other family members seen by us: _____

Employer: _____

Occupation: _____

Employer's Address: _____

_____

SPOUSE OR SIGNIFICANT OTHER INFORMATION (if applicable)

Spouse's name: _____

Spouse's Employer: _____

Work Phone: (____)_____Ext:_____

Spouse's Social Security Number: _____

Spouse's Birthdate: _____

ACCOUNT INFORMATION

Person Responsible for Account: _____

Relation: _____S.S.# _____

Home Phone: (____)_____

Work Phone: (____)_____Ext:_____

Billing Address: _____

_____

Employer: _____

Fill in below if you need our assistance in maximizing your insurance benefits.

PRIMARY DENTAL INSURANCE (if applicable)

Insurance Company Name: _____

Phone Number: (____)_____

Insurance Co. Address: _____

_____

Group Number: _____

Insured's Name: _____

Relation: _____

Insured's Birthdate: _____

Insured's Insurance ID Number:_____

Insured's Social Security Number: _____

Insured's Employer: _____

SECONDARY DENTAL INSURANCE (if applicable)

Insurance Company Name: _____

Phone Number:_____

Insurance Co. Address_____

Group Number: _____

Insured's Name: _____

Relation: _____

Insured's Birthdate: _____

Insured's Social Security Number: _____

Insured's Employer: _____

MEDICAL INSURANCE (if applicable)

Insurance Company Name: _____

Phone Number:_____

Insurance Co. Address_____

Group Number: _____

Insured's Name: _____

Relation: _____

Insured's Birthdate: _____

Insured's Social Security Number: _____

Insured's Employer: _____

MEDICAL HISTORY

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? Please list each one: _____

_____

_____

Do you have a personal physician? ☐Yes ☐No
Physician's Name:_____
Phone Number: _____Date of last visit: _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING: (circle)

Y	N	Asthma/Arthritis	Y	N	Kidney Problems
Y	N	Anemia/Radiation	Y	N	High/Low Blood Pressure
Y	N	Blood Transfusion	Y	N	Psychiatric Problems
Y	N	Cancer/Chemotherapy	Y	N	Severe/Frequent Headaches
Y	N	Congenital Heart Defect	Y	N	Shingles
Y	N	Diabetes	Y	N	Sinus Problems
Y	N	Difficulty Breathing	Y	N	Stroke
Y	N	Drug/Alcohol Abuse	Y	N	Tuberculosis (TB)
Y	N	Emphysema	Y	N	Venereal Disease
Y	N	Epilepsy/Seizure	Y	N	Artificial Bone/Joints
Y	N	Fever Blisters/Herpes	Y	N	Artificial Valves
Y	N	Glaucoma	Y	N	Heart Attack
Y	N	Hemophilia/Abnormal bleeding	Y	N	Heart Murmur
Y	N	Hepatitis	Y	N	Heart surgery/pacemaker
Y	N	HIV+/AIDS	Y	N	Mitral Valve Prolapse
Y	N	Hospitalized for any Reason	Y	N	Rheumatic/Scarlet Fever

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

_____

_____

Are you allergic to any of the following?

☐Aspirin ☐Latex
☐Codeine ☐Penicillin
☐Dental Anesthetics ☐Tetracycline
☐Erythromycin ☐Other_____

FOR WOMEN:

Are you taking birth control pills? ☐Yes ☐No
Type of birth control:_____
Are you pregnant? ☐Yes ☐No
Week #:_____
Are you nursing? ☐Yes ☐No

DENTAL HISTORY

Why have you come to the dentist today?

_____

Are you currently in pain? ☐Yes ☐No

Have you ever had any serious/difficult problems associated with any previous dental work? ☐Yes ☐No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ☐Yes ☐No

Your current dental health is: ☐Yes ☐No

Do you like to smile? ☐Yes ☐No

Do your gums ever bleed? ☐Yes ☐No

How many times a week do you floss? _____

How many times a day do you brush? _____

Have you had previous periodontal treatment? ☐Yes ☐No

If so, when and what? _____

IN THE EVENT OF AN EMERGENCY, WHO MAY WE CONTACT?

Name:_____Relation:_____

Work#: _____Home #: _____

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 (If patient is under 18, parent or guardian) Date

Payment is due in full at the time of treatment unless prior arrangements have been approved.

– OFFICE USE ONLY –

I have verbally reviewed the medical/dental information above with the patient named herein.

Signature:_____Date_____

Comments:_____

Signature:_____Date_____

Comments:_____

Signature:_____Date_____

Comments:_____

Signature:_____Date_____

Comments:_____

Signature:_____Date_____

Comments:_____

Signature:_____Date_____

Comments:_____