

# Welcome to our office



## 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?

- |   |                                       |
|---|---------------------------------------|
| <input type="checkbox"/> Aspirin            | <input type="checkbox"/> Latex        |
| <input type="checkbox"/> Codeine            | <input type="checkbox"/> Penicillin   |
| <input type="checkbox"/> Dental Anesthetics | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Erythromycin       | <input type="checkbox"/> 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: \_\_\_\_\_