WELCOME

Our goal is to care for our patients as we would care for our families. We will give optimal & quality service in a gentle & caring environment. We see you our patient as the heart of our practice and are here for you. We will give you respect, dignity & compassion.

PATIENT INFORMATION

Today's Date:

_____
Month Day Year

Full Name:

_____

I like to be called:_____

Home Address:

_____

_____
Apt/Condo# City State Zip

Home Phone: (___) _____

Work Phone: (___) _____ Ext.____

Pager/Car Phone: (___) _____

Email address: _____

Social Security Number:

_____

Birth date: ____/____/____
Month Day Year

Please Specify Gender: ❑ Male ❑ Female

Please Specify Martial Status:
❑ Single ❑ Married ❑ Divorced ❑ Widowed

Special interests, sports or hobbies:

_____

Student Status: ❑Yes ❑No **Grade:**_____
If Yes, School/College Name:

_____

Employer:_____

Address:_____

_____
Suite # City State Zip

Referred by:_____

EMERGENCY CONTACT

Name:_____

Relationship:_____

Phone: (___) _____

DENTAL INSURANCE

Do You Have Primary Insurance: ❑ Yes ❑ No

Insurance Carrier: _____

Group #: _____

Phone: (___) _____

Address: _____

_____
Suite # City State Zip

Employer: _____

Insurer's Name: _____

Social Security #: _____

Relationship to Patient:
❑ Self ❑ Spouse ❑ Parent ❑ Other

Birthdate: ____/____/____
Month Day Year

Do You Have Secondary Insurance: ❑ Yes ❑ No

Insurance Carrier: _____

Group #: _____

Phone: (___) _____

Address: _____

_____
Suite # City State Zip

Employer: _____

Insurer's Name: _____

Social Security #: _____

Relationship to Patient:
❑ Self ❑ Spouse ❑ Parent ❑ Other

Birthdate: ____/____/____
Month Day Year

MEDICAL HISTORY

Do you have a physician? ❑ Yes ❑ No

Physician Name: _____

MEDICAL HISTORY CONTINUED

Phone: (___) _____

Date of Last Visit: ____/____/____
Month Day Year

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

Do you smoke? ❑ Yes ❑ No

Do you need pre-medicated before dental treatment?
❑ Yes ❑ No

Are you under a physician's care? ❑ Yes ❑ No
If yes, please explain:_____

_____

Are you presently taking any medications or herbal supplements? ❑ Yes ❑ No
If yes, please explain:_____

_____

For women: Are you pregnant? ❑ Yes ❑ No
If yes, how many weeks?_____

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

Y N Anemia
Y N Arthritis / Joint Pain
Y N Asthma
Y N Cancer / Chemotherapy
Y N Chronic Hepatitis
Y N Diabetes
Y N Drug / Alcohol Abuse
Y N Epilepsy / Seizures / Fainting Spells
Y N Fever Blisters / Herpes
Y N Heart Attack / Stroke
Y N Heart Murmur / Rheumatic Fever
Y N Heart Surgery / Pacemaker
Y N Hemophilia / Abnormal Bleeding
Y N High / Low Blood Pressure
Y N HIV+ / AIDS
Y N Kidney Problems
Y N Psychiatric Problems
Y N Severe Headaches
Y N Shingles
Y N Sickle Cell Disease
Y N Sinus Problems
Y N Tuberculosis (TB); **Is It Active?** ❑ Yes ❑ No
Y N Prolonged Exposure to Tuberculosis Patient
Y N Unexplained Weight Loss
Y N Persistent Cough / Bloody Cough
Y N Night Sweats

Have you experienced any medical problems within the last 5 years not listed above? ❑ Yes ❑ No
If yes, please explain:_____

_____

Are you allergic to any of the following drugs?

Y	N	Aspirin	Y	N	Codeine
Y	N	Dental Anesthetics	Y	N	Tetracycline
Y	N	Erythromycin	Y	N	Penicillin
Y	N	Sulfa Drugs	Y	N	Latex

Are you allergic to any other drugs? ❑ Yes ❑ No
If yes, please explain?_____

DENTAL HISTORY

Why have you come to the dentist today?

_____

_____

Are you presently in pain? ❑ Yes ❑ No
Your current dental health is:
❑ Good ❑ Fair ❑ Poor
Are you under any unusual stress at home or work?
❑ Yes ❑ No
Do you experience stress or anxiety when you visit a dental office? ❑ Yes ❑ No

Date of your last dental visit:____/____/____
Month Day Year

Have you ever experienced TMJ problems?
❑ Yes ❑ No

Please answer yes or no to the following questions:

Y N Do you grind your teeth?
Y N Do you like your smile?
Y N Would you like to prevent dentures?
Y N Do your gums bleed when you brush your teeth?
Y N Are your gums red, swollen or tender?
Y N Have your gums pulled away from teeth?
Y N Do you have pus between teeth & gums when gums are pressed?
Y N Are permanent teeth loose or separating?
Y N Have you experienced a change in the way your teeth fit when biting?
Y N Have you had any change in fit of partial dentures?
Y N Do you experience persistent bad breath?

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

In our office, we do not want money to be an issue for you and your family. We will file insurance claim as a courtesy to our patients. Your co-payment is due in full at the time of treatment unless prior arrangements have been approved.

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help.