# Welcome

## About You

Today's Date : _____ Email Address:_____

**Name:** _____ I prefer to be called_____ ___Male ___Female

Last First Mi Mr Mrs Ms Dr

Birthdate: ___/ __/ __ Age:_____ Social Security #: _____ __Single __Married __Divorced __Widowed __Separated

**Home Address:** _____

Street City State Zip

Home Phone #: (___)_____ Cell #: (___) _____ Work #: (___) _____ Ext:_____

Driver License #:_____

Where & when are best times to reach you? _____ Whom may we Thank for referring you? _____

Other family members seen by us: _____

**Employer:** _____ How long there? _____ Occupation: _____

Employer's Address: _____

Street/PO Box City State Zip

## Neighbor or Relative not living with you

His / Her Name: _____ Relation: _____ Work #: (___) _____ Home #:(___) _____

Address: _____

Street/PO Box City State Zip

## Person Responsible for Account if other than yourself

Name: _____ Relation: _____ Home#: (___) _____ SSN#: _____

Employer: _____ Work#: (___) _____ Ext: _____ Drivers License #: _____

Billing Address: _____

Street/PO Box City State Zip

## SPOUSE INFORMATION

His / Her Name: _____ Birthdate: ____/ ____/ ____ SSN#_____

Employer: _____ Work #: (___)_____ Ext:_____ Drivers License #: _____

## INSURANCE INFORMATION

**Primary Insurance** Dental Coverage? ___Yes ___No Medical Coverage? ___Yes ___No Orthodontic Coverage? ___Yes ___No

Insurance Co. name:_____ Phone #: (___)_____ Group # (Plan, Local or Policy #) _____

Insurance Co. Address: _____

Street/PO Box City State Zip

Insured's Name: _____ Insured's SSN: _____ Insured's Birthdate: ___/ ___/ ___ Relation: _____

Insured's Employer: _____ Employer's Address: _____

Street/PO Box City State Zip

## DENTAL HISTORY

**Why have you come to the dentist today?** _____

_____

Are you currently in pain? ___Yes ___No
Do you require antibiotics before dental treatment? ___Yes ___No
Have you experienced problems associated with any previous dental work? ___Yes ___No
Do you no or have yu ever experienced pain / discomfort In your jaw joint (TMJ / TMD)? ___Yes ___No
Your current dental health is ___Good ___Fair ___Poor
Do you floss daily? ___Yes ___No Brush daily? ___Yes ___No
Type of bristles on your toothbrush? ___Hard ___Medium ___Soft
How long do you use a toothbrush before replacing it? _____
Do you use anything in addition to your brush and floss? ___Yes ___No
If yes, what? _____
Would you like fresher breath? ___Yes ___No Whiter Teeth ___Yes ___No

Do your gums ever bleed? ___Yes ___No Ever Itch? ___Yes ___No
Have you ever had periodontal disease? ___Yes ___No
Do you have mobility in your teeth? ___Yes ___No
Are your teeth sensitive to heat, cold, or anything else? _____
Do you still have wisdom teeth? ___Yes ___No
If yes, why? _____
Previous / Present Dentist: _____
(Please Circle)
Last Visit? _____
Why did you leave your previous dentist? _____
What did you like most & least about any dentist you have seen? _____
_____
**Are you happy with the way your smile looks?** ___Yes ___No
If not, what would you change? _____
_____

## MEDICAL HISTORY

Do you have a personal physician? ___Yes ___No Date of last visit:_____
Physician's Name:_____
Address:_____
Phone #:_____
**Your current physical health is:** ____Good ___Fair ___Poor
Are you currently under the care of a physician? ___Yes ___No
Please explain:_____
Do you smoke or use tobacco in any other form? ___Yes ___No
Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath? ___Yes ___No
Have you ever taken Fosamax, or any other Bisphosphonate? ___Yes ___No

**Are you allergic to any of the following?**

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

Please list additional drugs/materials that cause allergic reactions:_____
_____

**For Women:** Are you taking birth control pills? ___Yes ___No
Are you pregnant? ___Unsure ___Yes ___No
Week #: _____ Are you nursing? ___Yes ___No

## Are you taking any of the following?

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

Are you taking any prescription, over-the-counter drugs, herbal remedies, vitamins or minerals not listed above? ___Yes ___No If yes, please list each one:_____

_____

## Do you or have you experienced the following?

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

## 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**

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.

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 dentist 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.