

W E L C O M E

In order to ensure your maximum oral health and allow us to prescribe the proper medications, it is very important that we know all medical and dental information about you. Please check every box on the front and back of this form, even if the answer is "N/A" (not applicable). This information will be kept in the strictest confidence.

You also should know that changes in other parts of your body may affect the oral cavity and what dental treatment can be done, even if they seem unconnected. Cardiac (heart) problems, artificial joints and diabetes are just some examples.

Will you please inform the dentist or the staff at the beginning of each new office visit if your medical or dental conditions have changed since we last saw you? Yes No Thank you.

1

Patient Information

Date _____

Patient _____

Address _____

City _____ State _____ Zip _____

I prefer to be called: Mr. Mrs. Miss Other _____

Birthdate _____ Gender: F M Age _____

Single Married Widowed Separated Divorced

Patient SS# _____ - _____ - _____

If patient is a minor, give parent's or guardian's name: _____

Occupation _____

Employer _____

Spouse's Name _____

Spouse's Occupation _____

Spouse's Employer _____

How did you hear about us? _____

2

Phone Numbers

Home Phone _____

Work _____ Ext _____

Cell phone _____

Email _____

Family Physician's Name: _____

Physician's Phone: _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____

Relationship _____

Home Phone _____

Work Phone _____

3

Dental Insurance

Who is the policy holder? _____

SS# _____ Birthdate _____

Relationship to Patient: _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name: _____

Insurance Co.: _____

Group # _____

4

ASSIGNMENT AND RELEASE

I certify that I (or my dependent) have insurance coverage as indicated and assign directly to this office all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Relationship to Minor (if applicable)

Date

W E L C O M E

1

Dental History

Reason for today's visit _____

Former Dentist _____

Date of last dental visit _____

Date of last dental x-rays _____

Mark "Yes" or "No" to indicate if you presently have or previously had any of the following:

- Bad breath Yes No
- Bite your lips or cheeks regularly Yes No
- Bleeding gums Yes No
- Blisters on lips or mouth Yes No
- Chew on one side of mouth Yes No
- Dry mouth Yes No
- Food collection between the teeth Yes No
- Grinding teeth Yes No
- Gums swollen or tender Yes No
- Jaw pain or tiredness Yes No
- Mouth breathing Yes No
- Orthodontic treatment Yes No
- Pain around ear Yes No
- Periodontal (gum) treatment Yes No
- Sensitivity to cold Yes No
- Sensitivity to hot Yes No

Have you experienced:

- Clicking or popping of the jaw? Yes No
- Pain? (joint, ear, side of face) Yes No
- Difficulty in opening or closing the mouth? Yes No

How often do you floss? _____

How often do you brush? _____

Do you require antibiotics before dental treatment? Yes No

Are you currently in pain? Yes No

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

Do you like your smile? Yes No

Do you feel nervous about having dental treatment? Yes No

Have you ever had a bad experience in a dental office? Yes No

If yes, please describe _____

Is there anything else about having dental treatment that you would like us to know? _____

2

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? Yes No Please list each one: _____

Do you smoke or use tobacco in any other forms? Yes No

For Women:

- Are you taking birth control pills? Yes No
- Are you pregnant? Yes No
- Are you nursing? Yes No

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

- Abnormal Bleeding Yes No
- Alcohol / Drug Abuse Yes No
- Alzheimer's Disease Yes No
- Anemia Yes No
- Arthritis Yes No
- Artificial Bones / Joints / Valves Yes No
- Asthma Yes No
- Blood Transfusion Yes No
- Bruise Easily Yes No
- Cancer / Chemotherapy Yes No
- Colitis Yes No
- Diabetes Yes No
- Difficulty Breathing Yes No
- Emphysema Yes No
- Epilepsy Yes No
- Fainting Spells Yes No
- Frequent Headaches Yes No

- Glaucoma Yes No
- Hay Fever Yes No
- Heart Problems Yes No
- Heart Murmur Yes No
- Hemophilia Yes No
- Hepatitis Yes No
- Herpes / Fever Blisters Yes No
- High Blood Pressure Yes No
- HIV+ / AIDS Yes No
- Hospitalized for Any Reason Yes No
- Joint Replacement Yes No
- Kidney Problems Yes No
- Liver Disease Yes No
- Low Blood Pressure Yes No
- Mitral Valve Prolapse Yes No
- Nervous/Anxious Yes No
- Pacemaker Yes No
- Psychiatric/Psychological Care Yes No
- Radiation Treatment Yes No
- Rheumatic / Scarlet Fever Yes No
- Seizures Yes No
- Sinus Problems Yes No
- Stroke Yes No
- Thyroid Problems Yes No
- Tuberculosis (TB) Yes No
- Tumors or Growths Yes No
- Ulcers Yes No
- Venereal Disease Yes No

Do you have or have you had any disease, condition, or problem not listed? Yes No

Are you allergic to any of the following?

- Aspirin Yes No
- Codeine Yes No
- Dental Anesthetics Yes No
- Latex Yes No
- Metals Yes No
- Penicillin Yes No
- Tetracycline Yes No

Please list any other drugs/materials that you are allergic to: _____

3

CERTIFICATION: I certify that the answers given are correct to the best of my knowledge.

Signature _____ Date _____