Welcome

Our goal is to help you reach and maintain maximum oral health.
Please fill out this form completely.

About You

Today's Date _____

E-Mail address: _____

Name : _____

I prefer to be called _____

Birthdate: ___/___/____ Age:___SS#_____

Home Address: _____

_____

__Single __Married__Divorced___Widowed___Separated

Hm# (____) _____Cell# _____

Wk# (____) _____Ext:____DL#_____

Employer: _____

Employer's Address_____

Occupation_____

Where & When are best times to reach you? _____

Whom may we Thank for referring you? _____

Other Family members seen by us: _____

Previous/Present Dentist_____

Last Visit Date:_____

Spouse Information

His/Her Name:_____

Employer: _____

Wk# (____)_____Ext:_____SS#: _____

Birthdate___/___/___DL#: _____

Insurance

Primary Insurance-Dental

Insurance Co. Name_____

Insurance Co. Address_____

Insurance Co Phone# _____

Group # or Policy #_____

Insured's Name_____Relation:_____

Insured's Birthdate ___/___/____Insured's ID#_____

Insured's Employer:_____

Employer's Address: _____

Secondary Insurance-Dental

Insurance Co. Name_____

Insurance Co. Address_____

Insurance Co Phone# _____

Group # or Policy #_____

Medical History

Do you have a personal physician? Yes No

Physician's Name: _____

Phone #: (____)_____Date of last visit:_____

Are you currently under the care of a physician? Yes No

Please explain: _____

Medical History Continued

Your current physical health is: Good Fair Poor

Do you smoke or use tobacco in any other form? Yes No
Have you had any metal rods, pins or implants? Yes No
Have you ever taken Fosamax? Yes No

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

Y N	Abnormal Bleeding	Y N	Herpes/Fever Blisters
Y N	Alcohol/Drug Abuse	Y N	High Blood Pressure
Y N	Anemia	Y N	HIV+/ AIDS
Y N	Arthritis	Y N	Kidney Problems
Y N	Artificial Bones/Joints	Y N	Liver Disease
Y N	Asthma	Y N	Low Blood Pressure
Y N	Blood Transfusion	Y N	Lupus
Y N	Cancer/Chemotherapy	Y N	Osteoporosis/Paget's Disease
Y N	Mitral Value Prolapse	Y N	Shingles
Y N	Congenital Heart Defect	Y N	Pacemaker
Y N	Diabetes	Y N	Psychiatric Treatment
Y N	Difficulty Breathing	Y N	Seizures
Y N	Emphysema	Y N	Radiation Treatment
Y N	Epilepsy	Y N	Rheumatic/ Scarlet Fever
Y N	Fainting Spells	Y N	Stroke
Y N	Frequent Headaches	Y N	Tuberculosis (TB)
Y N	Sinus Problems	Y N	Heart Attack
Y N	Heart Murmur	Y N	Heart Surgery
Y N	Hemophilia	Y N	Hepatitis

Are you allergic to any of the following?

Y N	Aspirin	Y N	Erythromycin	Y N	Tetracycline
Y N	Codeine	Y N	Latex	Y N	Penicillin
Y N	Dental Anesthetics			Y N	Other

Are you taking any prescriptions? Y N
Please list each one: _____
_____
_____

Dental History

Why have you come to the dentist today? _____

_____

Do you require antibiotics before dental treatment? Yes No
Are you currently in pain? Yes No
Do you have fears about going to the dentist? Yes No

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 Date

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I verbally reviewed the medical/dental information above with the patient named herein. Initials:_____Date_____

Doctor's Comments: _____

_____

I have read my medical history dated _____and confirmed that it states past and present medical conditions. _____
Signature Date

I have read my medical history dated _____and confirmed that it states past and present medical conditions. _____
Signature Date

I have read my medical history dated _____and confirmed that it states past and present medical conditions. _____
Signature Date