

# WELCOME

## ≈SECTION ONE - ABOUT YOU≈

Today's Date: \_\_\_\_\_ SS#: \_\_\_\_\_

Name: \_\_\_\_\_  
Last First Middle Name

I prefer to be called: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_  Male  Female

Home Address: \_\_\_\_\_  
City State Zip Code

Single  Married  Divorced  Widowed  Separated

Home #: (\_\_\_\_) \_\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_\_ Work #: (\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ How long there? \_\_\_\_\_

Address: \_\_\_\_\_

Whom may we Thank for referring you? \_\_\_\_\_ Other family members seen by us: \_\_\_\_\_

Previous/Present Dentist: \_\_\_\_\_ Phone #: \_\_\_\_\_ Last Visit Date: \_\_\_\_\_

## ≈SECTION TWO - SPOUSE INFORMATION≈

His/Her Name: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS #: \_\_\_\_\_

Employer: \_\_\_\_\_ Work #: (\_\_\_\_) \_\_\_\_\_

PERSON RESPONSIBLE FOR ACCOUNT: \_\_\_\_\_ Relationship: \_\_\_\_\_

Billing Address: \_\_\_\_\_ SS #: \_\_\_\_\_

Home #: (\_\_\_\_) \_\_\_\_\_ Work #: (\_\_\_\_) \_\_\_\_\_ Employer: \_\_\_\_\_

## ≈SECTION THREE - INSURANCE≈

**PRIMARY INSURANCE** Dental Coverage  YES  NO

Insurance Co. Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Group # (Plan, Local, Policy): \_\_\_\_\_ Insured's ID#: \_\_\_\_\_ Insured's Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

Insured's Employer: \_\_\_\_\_ Address: \_\_\_\_\_

**SECONDARY INSURANCE** Dental Coverage  YES  NO

Insurance Co. Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Group # (Plan, Local, Policy): \_\_\_\_\_ Insured's ID#: \_\_\_\_\_ Insured's Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

Insured's Employer: \_\_\_\_\_ Address: \_\_\_\_\_

## ≈SECTION FOUR - DENTAL HISTORY≈

WHY HAVE YOU COME TO THE DENTIST TODAY? \_\_\_\_\_

Are you currently in pain?  YES  NO Have you ever had gum treatment?  YES  NO Gums bleed?  YES  NO

Are your teeth sensitive?  YES  NO Lost any teeth?  YES  NO Your current dental health is  Good  Fair  Poor

Do you require antibiotics before dental work?  YES  NO Any problems with previous dental work?  YES  NO

How often do you brush? \_\_\_\_\_ How often do you floss? \_\_\_\_\_ Type of bristles?  Hard  Medium  Soft

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)?  YES  NO

Do you have any pain associated with your face, head or neck?  YES  NO Do you like your smile?  YES  NO

**≈SECTION FIVE - MEDICAL HISTORY≈**

**IN CASE OF EMERGENCY WHO SHOULD WE CONTACT:** \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Are you currently under the care of a physician? Why? \_\_\_\_\_

Date of Last visit: \_\_\_\_\_ Your current physical health is  Good  Fair  Poor

Do you smoke or use tobacco?  YES  NO Have you had any metal rods, pins or implants?  YES  NO

Are you taking any prescription, over-the-counter or herbal supplement drugs?  YES  NO Please list: \_\_\_\_\_

**HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS**

- |     |                               |     |                             |     |                         |
|-----|-------------------------------|-----|-----------------------------|-----|-------------------------|
| Y N | Abnormal Bleeding/Hemophilia  | Y N | Fainting Spells             | Y N | Pacemaker               |
| Y N | Alcohol/Drug Abuse            | Y N | Frequent Headaches          | Y N | Psychiatric Problems    |
| Y N | Anemia                        | Y N | Glaucoma                    | Y N | Radiation Treatment     |
| Y N | Arthritis                     | Y N | Hay Fever                   | Y N | Rheumatic Fever         |
| Y N | Artificial Bone/Joints/Valves | Y N | Heart Attack/Surgery        | Y N | ringing in ears         |
| Y N | Asthma                        | Y N | Heart Murmur                | Y N | Scarlet Fever           |
| Y N | Blood Transfusion             | Y N | Hepatitis                   | Y N | Seizures                |
| Y N | Cancer/Chemotherapy           | Y N | Herpes/Fever Blisters       | Y N | Shingles                |
| Y N | Colitis                       | Y N | High Blood Pressure         | Y N | Sickle Cell Dis./Traits |
| Y N | Congenital Heart Defect       | Y N | Hospitalized for any reason | Y N | Sinus Problems          |
| Y N | Diabetes                      | Y N | Kidney Problems             | Y N | Stroke                  |
| Y N | Difficulty Breathing          | Y N | Liver Disease               | Y N | Thyroid Problems        |
| Y N | Dizziness                     | Y N | Low Blood Pressure          | Y N | Tuberculosis (TB)       |
| Y N | Emphysema                     | Y N | Lupus                       | Y N | Ulcers                  |
| Y N | Epilepsy                      | Y N | Mitral Valve Prolapse       | Y N | Venereal Disease        |
| Y N | Trouble falling asleep        | Y N | Trouble staying asleep      | Y N | Wake Rested             |

Please list any serious medical conditions that you have ever had: \_\_\_\_\_

**ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?**

- |     |                    |     |               |     |              |
|-----|--------------------|-----|---------------|-----|--------------|
| Y N | Aspirin            | Y N | Erythromycin  | Y N | Penicillin   |
| Y N | Codeine            | Y N | Jewelry/Metal | Y N | Tetracycline |
| Y N | Dental Anesthetics | Y N | Latex         | Y N | Other        |

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

Have you ever taken Fosamax, Actonel, Boniva or any other bisphosphonate?  YES  NO

**FOR WOMEN:** Are you using birth control?  YES  NO Pregnant?  YES  NO Due: \_\_\_\_\_ Nursing?  YES  NO

Anything you would like to discuss with the dentist in private?  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.*

**SIGNATURE**

**DATE**

**PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT  
UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.**

*If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.*

**SIGNATURE**

**DATE**

**FOR OFFICE USE ONLY**

Reviewed medical/dental information with patient: \_\_\_\_\_ Date: \_\_\_\_\_

Comments: \_\_\_\_\_