

# WELCOME

## Personal Information

Today's Date \_\_\_\_\_ E-mail Address \_\_\_\_\_

Name \_\_\_\_\_  
Last First MI Mr. Mrs. Ms. Dr.

I prefer to be called: \_\_\_\_\_  Male  Female

Birth date: \_\_\_ / \_\_\_ / \_\_\_ Age: \_\_\_ SS# \_\_\_\_\_

Home Address \_\_\_\_\_

Single  Married  Divorced  Widowed  Separated

Hm #: ( \_\_\_ ) \_\_\_\_\_ Pager/Cell #: \_\_\_\_\_

Wk #: ( \_\_\_ ) \_\_\_\_\_ Ext: \_\_\_ DL#: \_\_\_\_\_

Employer: \_\_\_\_\_

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

How long there? \_\_\_\_\_ 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: \_\_\_\_\_  
(please circle)

Last Visit Date: \_\_\_\_\_

## Insurance Continued

### Secondary Insurance

Medical Coverage?  Yes  No Dental Coverage?  Yes  No

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

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

Insurance Co. Phone #:( \_\_\_ ) \_\_\_\_\_

Group # (Plan, Local or Policy #): \_\_\_\_\_

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

Insured's Birth date: \_\_\_ / \_\_\_ / \_\_\_ Insured's SS#: \_\_\_\_\_

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

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

### Person to contact if you are not available

His/Her Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Wk #:( \_\_\_ ) \_\_\_\_\_ Hm #:( \_\_\_ ) \_\_\_\_\_

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

City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## 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

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

Have you ever had gum treatment?  Yes  No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)  Yes  No

Your current dental health is  Good  Fair  Poor

Do you like your smile?  Y  N Do your gums ever bleed?  Y  N

How many times a week do you floss? \_\_\_\_\_

How many times a day do you brush? \_\_\_\_\_

Type of bristles?  Soft  Medium  Hard

**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 \_\_\_\_\_

## Spouse Information

His/Her Name: \_\_\_\_\_

Employer: \_\_\_\_\_

Wk #: ( \_\_\_ ) \_\_\_\_\_ Ext: \_\_\_ SS#: \_\_\_\_\_

Birth date: \_\_\_ / \_\_\_ / \_\_\_ DL#: \_\_\_\_\_

## Insurance

### Primary Insurance

Medical Coverage? Yes No Dental Coverage? Yes No

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

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

Insurance Co. Phone #:( \_\_\_ ) \_\_\_\_\_

Group # (Plan, Local or Policy #): \_\_\_\_\_

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

Insured's Birth date: \_\_\_ / \_\_\_ / \_\_\_ Insured's SS#: \_\_\_\_\_

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

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

## Medical History

Do you smoke or use tobacco products? Yes  No  Do you have any metal rods, pins or implants? Yes  No

Are you currently taking any prescription or over the counter supplements? Yes  No

If yes please list medications: \_\_\_\_\_

### For Woman Only

Are you currently pregnant? Yes  No  Total Weeks #: \_\_\_\_\_

Are you nursing? Yes  No

### Have you ever had any of the following disease or medical problems?

Yes <input type="checkbox"/> No <input type="checkbox"/>	Abnormal Bleeding	Yes <input type="checkbox"/> No <input type="checkbox"/>	High Blood Pressure
Yes <input type="checkbox"/> No <input type="checkbox"/>	Alcohol/Drug Abuse	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hospitalization for any reason
Yes <input type="checkbox"/> No <input type="checkbox"/>	Anemia	Yes <input type="checkbox"/> No <input type="checkbox"/>	Kidney Problems
Yes <input type="checkbox"/> No <input type="checkbox"/>	Artificial Bones/Joints/Valves	Yes <input type="checkbox"/> No <input type="checkbox"/>	Liver Disease
Yes <input type="checkbox"/> No <input type="checkbox"/>	Asthma	Yes <input type="checkbox"/> No <input type="checkbox"/>	Low Blood Pressure
Yes <input type="checkbox"/> No <input type="checkbox"/>	Blood Fusion	Yes <input type="checkbox"/> No <input type="checkbox"/>	Lupus
Yes <input type="checkbox"/> No <input type="checkbox"/>	Cancer/Chemotherapy	Yes <input type="checkbox"/> No <input type="checkbox"/>	Mitral Valve Prolapse
Yes <input type="checkbox"/> No <input type="checkbox"/>	Colitis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Pacemaker
Yes <input type="checkbox"/> No <input type="checkbox"/>	Congenital Heart Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Psychiatric Problems
Yes <input type="checkbox"/> No <input type="checkbox"/>	Diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/>	Radiation Treatment
Yes <input type="checkbox"/> No <input type="checkbox"/>	Difficulty Breathing	Yes <input type="checkbox"/> No <input type="checkbox"/>	Rheumatic/Scarlet fever
Yes <input type="checkbox"/> No <input type="checkbox"/>	Emphysema	Yes <input type="checkbox"/> No <input type="checkbox"/>	Seizures
Yes <input type="checkbox"/> No <input type="checkbox"/>	Fainting Spells	Yes <input type="checkbox"/> No <input type="checkbox"/>	Shingles
Yes <input type="checkbox"/> No <input type="checkbox"/>	Frequent Headaches	Yes <input type="checkbox"/> No <input type="checkbox"/>	Sickle Cell Disease/Traits
Yes <input type="checkbox"/> No <input type="checkbox"/>	Glaucoma	Yes <input type="checkbox"/> No <input type="checkbox"/>	Sinus Problems
Yes <input type="checkbox"/> No <input type="checkbox"/>	Hay Fever	Yes <input type="checkbox"/> No <input type="checkbox"/>	Stroke
Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart Attack/Surgery	Yes <input type="checkbox"/> No <input type="checkbox"/>	Thyroid Problems
Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart Murmur	Yes <input type="checkbox"/> No <input type="checkbox"/>	Tuberculosis (TB)
Yes <input type="checkbox"/> No <input type="checkbox"/>	Hepatitis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Ulcers
Yes <input type="checkbox"/> No <input type="checkbox"/>	Herpes	Yes <input type="checkbox"/> No <input type="checkbox"/>	Venereal Disease
Yes <input type="checkbox"/> No <input type="checkbox"/>	Fever Blister		

Do you take a bone-building drug such as Fosamax, Actonel, Zometa, Aredia or pamidronate? If so, orally or IV? \_\_\_\_\_

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

Yes <input type="checkbox"/> No <input type="checkbox"/>	Aspirin	Yes <input type="checkbox"/> No <input type="checkbox"/>	Erythromycin	Yes <input type="checkbox"/> No <input type="checkbox"/>	Penicillin
Yes <input type="checkbox"/> No <input type="checkbox"/>	Codeine	Yes <input type="checkbox"/> No <input type="checkbox"/>	Metals	Yes <input type="checkbox"/> No <input type="checkbox"/>	Tetracycline
Yes <input type="checkbox"/> No <input type="checkbox"/>	Dental Anesthetic	Yes <input type="checkbox"/> No <input type="checkbox"/>	Latex	Yes <input type="checkbox"/> No <input type="checkbox"/>	Other

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

Reason for today's appointment: \_\_\_\_\_ Do you like your smile? Yes  No  Does your gums ever bleed? Yes  No

Type of toothbrush bristles?  Hard  Medium  Soft How many times do you brush in a week? \_\_\_\_\_

How many times do you floss in a week? \_\_\_\_\_ Are your teeth sensitive to hot or cold? Yes  No  Have you lost any of your teeth? Yes  No

If yes, please explain: \_\_\_\_\_

I understand that the information that I have provided today is correct to the best of my knowledge. I understand that this information will be confidential, and I will inform the office if there's any change in my medical condition.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date