

# Welcome

Today's Date: \_\_\_\_\_

## ABOUT YOU

Name: \_\_\_\_\_

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

( ) Single ( ) Married ( ) Divorced ( ) Widowed ( ) Separated

Birthdate: \_\_\_\_\_ SSN: \_\_\_\_\_ Driver's License: \_\_\_\_\_

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

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

E-Mail Address: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Pager-Car Number: \_\_\_\_\_

Work Phone Number: \_\_\_\_\_ Ext: \_\_\_\_\_

Where & when are the 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 \_\_\_\_\_

### PERSON RESPONSIBLE FOR ACCOUNT IF OTHER THAN YOURSELF

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Work Phone Number: \_\_\_\_\_ Home Phone Number: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Driver's License Number: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_ Ext: \_\_\_\_\_

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

Street: \_\_\_\_\_

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

**SPOUSE INFORMATION**

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

Birthdate: \_\_\_\_\_ SSN: \_\_\_\_\_ Driver's License Number: \_\_\_\_\_

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

Work Phone Number: \_\_\_\_\_ Ext: \_\_\_\_\_

**INSURANCE INFORMATION**

**Primary Insurance** ..... Dental Coverage? ( ) Yes ( ) No

**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

- Have you 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? ( ) Yes ( ) No

- Do you still have wisdom teeth? ( ) Yes ( ) No

If yes, why? \_\_\_\_\_

- Previous / Present Dentist: \_\_\_\_\_ Last Visit Date: \_\_\_\_\_

- 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

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

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

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

Phone Number: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

- 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

- Are you allergic to any of the following?

- |                |                    |                |              |
|----------------|--------------------|----------------|--------------|
| ( ) Yes ( ) No | Aspirin            | ( ) Yes ( ) No | Latex        |
| ( ) Yes ( ) No | Barbiturates       | ( ) Yes ( ) No | Penicillin   |
| ( ) Yes ( ) No | Codeine            | ( ) Yes ( ) No | Sedatives    |
| ( ) Yes ( ) No | Dental Anesthetics | ( ) Yes ( ) No | Sulfa Drugs  |
| ( ) Yes ( ) No | Erythromycin       | ( ) Yes ( ) No | Tetracycline |
| ( ) Yes ( ) No | Jewelry / Metals   | ( ) Yes ( ) No | 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 Number: \_\_\_\_\_ Are you nursing? ( ) Yes ( ) No

**Are you taking any of the following?(Please Circle)**

- |                                |                        |                            |
|--------------------------------|------------------------|----------------------------|
| Y N Acetaminophen              | Y N Blood Thinners     | Y N Insulin/Diabetes Drugs |
| 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/Cortison  |                            |

- 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 have or have you experienced the following?**

- |  |                         |                        |
|--|-------------------------|------------------------|
| Y N Heart Attack                         | Y N Hepatitis           | Y N Kidney Disease     |
| Y N Heart Surgery                        | Y N Anemia              | Y N Liver Disease      |
| Y N Congenital Heart Defect              | Y N Sickle Cell Disease | Y N Thyroid Problems   |
| Y N Heart Murmur                         | Y N Diabetes            | Y N Lupus              |
| Y N Mitral Valve Prolaps                 | Y N Asthma              | Y N Tumor or Growth    |
| Y N High/Low Blood Pressure              | Y N Emphysema           | Y N Chemotherapy       |
| Y N Pacemaker                            | Y N Arthritis           | Y N Radiation Therapy  |
| Y N Artificial Heart Valves              | Y N Tuberculosis        | Y N Venereal Disease   |
| Y N Blood Transfusion                    | Y N Ulcers              | Y N HIV+/AIDS          |
| Y N Rheumatic Fever                      | Y N Seizures            | Y N Drug/Alcohol Abuse |
| Y N Stroke                               | Y N Sinus Problems      | Y N Glaucoma           |
| Y N Abnormal Bleeding                    | Y N Headaches           | Y N Artificial Joints  |
| Y N Hospitalization for any other reason |                         |                        |

**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**

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.

\_\_\_\_\_  
Signature Date