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WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out these forms completely. The better we communicate, the better we can care for you.

Today's Date _____

1) ABOUT YOU

NAME _____
last first Mr. Mrs. Ms. Dr.

I prefer to be called _____ _____Male _____Female

Birthdate _____ / _____ / _____ Age _____ S.S.# _____

Home Address _____

_____
City State Zip

_____ Single _____ Married _____ Divorced _____ Widowed _____ Separated

Home # _____ Pager / Other # _____

Work # _____ Ext. _____

Cell # _____ Email _____

Employer _____

Employer's Address _____

How long there? _____ Occupation _____

Where and when are the best times to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us _____

SPOUSE INFORMATION

His / Her Name _____

Employer _____

Work # _____ Ext _____ S.S. #_____

Birthdate _____ / _____ / _____

DENTAL INSURANCE

Primary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

_____

Insurance Co. Phone # _____

Group # (Plan, Local, or Policy #) _____

Insured's Name _____ Relation _____

Insured's Birthday _____ / _____ / _____ Insured's S.S. # _____

Insured's Employer _____

Secondary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

_____

Insurance Co. Phone # _____

Group # (Plan, Local, or Policy #) _____

Insured's Name _____ Relation _____

Insured's Birthday _____ / _____ / _____ Insured's S.S. # _____

Insured's Employer _____

2) MEDICAL HISTORY Do you have a personal Physician? Y / N

Physician's Name _____

Phone # _____ Date of Last Visit _____

Your current physical health is _____ Good _____ Fair _____ Poor

Are you currently under the care of a Physician? Y / N

Please explain _____

Are you a tobacco smoker? Y / N How much per day _____

Are you taking any prescription / over-the-counter drugs? Y / N

Please list each one _____

Have you ever traveled to Sierra Leona, Liberia, Guinea? Y / N If so, when? _____

FOR WOMEN: Are you taking birth control pills? Y / N

Are you pregnant? Y / N Week # _____

Are you nursing? Y / N

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

Y / N	Heart Attack	Y / N	High Blood Pressure	Y / N	Ulcers
Y / N	Stroke	Y / N	Low Blood Pressure	Y / N	Colitis
Y / N	Cancer	Y / N	Fever Blisters	Y / N	Congenital Heart Defect
Y / N	Chemotherapy	Y / N	Severe Headaches	Y / N	Anemia
Y / N	Heart Murmur	Y / N	Frequent Headaches	Y / N	Radiation Treatment
Y / N	Rheumatic Fever	Y / N	Psychiatric Problems	Y / N	Asthma
Y / N	HIV/AIDS	Y / N	Epilepsy	Y / N	Arthritis
Y / N	Heart Surgery	Y / N	Seizures	Y / N	Difficulty Breathing
Y / N	Pacemaker	Y / N	Fainting	Y / N	Emphysema
Y / N	Shingles	Y / N	Diabetes	Y / N	Hospitalized for any reason
Y / N	Mitral Valve Prolapse	Y / N	Tuberculosis (TB)	Y / N	Hepatitis
Y / N	Kidney Problems	Y / N	Drug Abuse	Y / N	Blood Transfusion
Y / N	Osteoporosis	Y / N	Alcohol Abuse	Y / N	Glaucoma
Y / N	Artificial Joints	Y / N	Venereal Disease	Y / N	Thyroid Problems
Y / N	Artificial Valves	Y / N	Hemophilia	Y / N	Seasonal Allergies
Y / N	Sinus Problems	Y / N	Abnormal Bleeding		

Please list any serious medical condition(s) that you have ever had, or if you have been hospitalized _____

_____

Are you allergic to any of the following drugs?

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

Please list any other drugs that you are allergic to _____

_____

3) DENTAL HISTORY

1. Previous / Present Dentist _____

   Last Visit Date _____

2. Why have you come to the dentist today? _____

   _____

3. Did you have problems with your last dentist Y / N _____

   a) What procedures were performed? _____

4. Have you had any teeth extracted or lost any teeth? _____

   For what reason? _____

5. Did you have complications with extraction Y / N _____

6. Have you ever had bridgework or dentures Y / N _____

   Have you ever had dental implants? _____

7. Are your teeth sensitive to Hot _____ Cold _____ Sweet _____ (check one)

   Are your teeth sensitive when you get them cleaned? _____

8. Did you wear braces? Y / N

9. Check what you use:

   a. Brush _____ d. Floss _____

   b. Electric Brush _____ e. Other _____

   c. Water Pik _____

10. Do your gums bleed? Y / N

11. Did you ever go to a periodontist? Y / N

    Name of Periodontist _____ Phone # _____

    a. Did he perform gum surgery? Y / N When? _____

12. Do you have bad breath? Y / N

13. Are you aware of any lumps or swelling in your mouth? Y / N _____

14. Do you or did you ever have TMJ jaw problems? Y / N _____

15. How do you feel about your teeth? _____

    Would you like your teeth whiter? _____

    Would you like your teeth straighter? _____

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 of confidences, 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 with my informed consent that I may need during diagnosis and treatment.

_____ _____

Signature Date