

W E L C O M E

In order to ensure your maximum oral health and allow us to prescribe the proper medications, it is very important to that we know all medical and dental information about you. Please check every box on the front and back of this form, even if the answer is "N/A" (not applicable). This information will be kept in the strictest confidence.

You also should know that changes in other parts of your body may affect the oral cavity and what dental treatment can be done, even if they seem unconnected. Cardiac (heart) problems, artificial joints and diabetes are just some examples.

Will you please inform the dentist or the staff at the beginning of each new office visit if your medical or dental conditions have changed since we last saw you? Yes / No. Thank you.

1 PATIENT INFORMATION

Date _____
Patient _____
Address _____

City _____ State _____ Zip _____
I prefer to be called: Mr. Mrs. Miss Other _____
Birth Date: _____ Gender: F / M Age: _____
Patient SS#: _____
If patient is a minor, give parent's or guardian's name:

Occupation: _____
Employer: _____
Spouse's Name: _____
Spouse's Occupation: _____
Spouse's Employer: _____
Whom may we thank for referring you? _____

2 Phone Numbers

Home Phone _____
Work _____ Ext. _____
Cell Phone _____
Email Address _____
Spouse's Work _____
Best time and place to reach you _____
Family Physician's name _____
Physician's phone _____

IN CASE OF AN EMERGENCY, CONTACT *(Specify someone who does not live in your household)*
Name _____
Relationship _____
Home Phone _____

3 DENTAL INSURANCE

Who is responsible for this account? _____
SS#: _____ Birth Date _____
Relationship to patient _____
Insurance Co. _____
Group#: _____
Is patient covered by additional insurance? Yes / No
Subscriber's Name _____
Insurance Co. _____
Group#: _____

4 ASSIGNMENT AND RELEASE

I certify that I (or my dependent) have insurance coverage as indicated and assign directly to this office all insurance benefits otherwise payable to me for service rendered. I understand that I am responsible for all charges whether or not paid by insurance. I authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Relationship to Minor (if applicable)

Date

W E L C O M E

1

DENTAL HISTORY

Reason for today's visit _____

Former Dentist _____

Date of last dental visit _____

Date of last dental x-rays _____

Mark "Yes" or "No" to indicate if you presently have or previously had any of the following:

- Bad breath Yes / No
- Bite your lips or cheek regularly Yes / No
- Bleeding gums Yes / No
- Blisters on lips or mouth Yes / No
- Chew on one side of mouth Yes / No
- Dry mouth Yes / No
- Food collection between the teeth Yes / No
- Grinding teeth Yes / No
- Gums swollen or tender Yes / No
- Jaw pain or tiredness Yes / No
- Mouth breathing Yes / No
- Orthodontic treatment Yes / No
- Pain around ear Yes / No
- Periodontal (gum) treatment Yes / No
- Sensitivity to cold Yes / No
- Sensitivity to hot Yes / No

Have you experienced:

- Clicking or popping of the jaw? Yes / No
- Pain? (Joint, ear side of face) Yes / No
- Difficulty in opening and closing of the mouth? Yes / No

How often do you floss? _____

How often do you brush? _____

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

Do you like your smile? Yes / No

Do you feel nervous about having dental treatment? Yes / No

Have you ever had a bad experience in a dental office? Yes / No
If yes, please describe _____

Is there anything else about having dental treatment that you would like us to know?

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MEDICAL HISTORY

Your current physical condition is:

___Good ___Fair ___Poor

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

Please explain _____

Are you taking any prescription / over the counter drugs? Yes / No

Please list each one:

Do you smoke or use tobacco in any other forms? Yes / No

For Women:

Are you taking birth control pills? Yes / No

Are you pregnant? Yes / No

Are you nursing? Yes / No

Do you have or have you ever had any of the following diseases or medical problems?

- Abnormal Bleeding Yes / No
- Alcohol / Drug Abuse Yes / No
- Alzheimer's Disease Yes / No
- Anemia Yes / No
- Arthritis Yes / No
- Artificial Bones / Joints / Valves Yes / No
- Asthma Yes / No
- Blood Transfusion Yes / No
- Bruise Easily Yes / No
- Cancer / Chemotherapy Yes / No
- Colitis Yes / No
- Diabetes Yes / No
- Difficulty Breathing Yes / No
- Emphysema Yes / No
- Epilepsy Yes / No
- Fainting Spells Yes / No
- Frequent Headaches Yes / No
- Glaucoma Yes / No

- Hay Fever Yes / No
- Heart Problems Yes / No
- Heart Murmur Yes / No
- Hemophilia Yes / No
- Hepatitis Yes / No
- Herpes / Fever Blisters Yes / No
- High Blood Pressure Yes / No
- HIV+ / AIDS Yes / No
- Hospitalized for Any Reason Yes / No
- Joint Replacement Yes / No
- Kidney Problems Yes / No
- Liver Disease Yes / No
- Low Blood Pressure Yes / No
- Mitral Valve Prolapse Yes / No
- Nervous / Anxious Yes / No
- Pacemaker Yes / No
- Psychiatric/Psychological Care Yes / No
- Radiation Treatment Yes / No
- Rheumatic/Scarlet Fever Yes / No
- Seizures Yes / No
- Sinus Problems Yes / No
- Stroke Yes / No
- Thyroid Problems Yes / No
- Tuberculosis (TB) Yes / No
- Tumors or Growths Yes / No
- Ulcers Yes / No
- Venereal Disease Yes / No

Do you have or have you had and disease, condition, or problem not listed? Yes / No

- Are you allergic to any of the following?
- Aspirin Yes / No
 - Codeine Yes / No
 - Dental Anesthetics Yes / No
 - Latex Yes / No
 - Metals Yes / No
 - Penicillin Yes / No
 - Tetracycline Yes / No

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

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CERTIFICATION: I certify that the answers given are correct to the best of my knowledge.

Signature _____ Date _____