Welcomes You!

About You

Today's Date: ______________ E-mail Address: ______________________________________

Name: ____ Preferred name: __________ Male/Female
(Last) (First) (Mi)

Birthdate: ____/____/_____ Age: ____ Social Security #: ________________ Marital Status: ______________

Home Address: ____
(Street) (City) (State) (Zip)

Home Phone #: (____)______________ Cell #: (____) ____________ Work Phone #: (____) ____________

Driver's License #: __________________ Whom may we thank for referring you? ______________________

Employer: __________________________ Occupation: ___________________________

Neighbor or relative not living with you

Name: ___________________ Relationship: _________ Phone #: (___)_________ Cell #: (___)__________

Address: ____
(Street) (City) (State) (Zip)

Responsible Party, If other than Yourself

Name: ______________________________ Relationship: ______________ Phone #: (___)_____________
Social Security #: ________________ Employer: ____________________ Work #: (____)_______________

Billing Address: ____
(Street) (City) (State) (Zip)

Spouse Information

Name: ______________________________ Birthdate: ___/___/___ Employer: ________________________
Work #: (___)____________ Cell#: (___) ___________

Dental Insurance Information

Do you have DENTAL Insurance? If yes, who is the POLICY HOLDER? ______________________________

Policy Holder's SS#: __________ Policy Holder's DOB: ___/___/___ Policy Holder's Employer:______________

Policy Holder's Employer:______________ Insurance Company: ______________ Phone #: (___)__________
Is there secondary coverage? If yes, Please provide us with the same information needed for your primary.

Please give all insurance cards to receptionist for copies.

Medical History

Physician's Name: ____________________ Phone #: (___)______________ Date of last visit:__________________

Your current physical health is: Good Fair Poor Do you use tobacco products? Y/N ____________, _____/ day

Are you currently under the care of a physician? ____ If yes, explain:____

____

Women: Are you taking birth control pills? ______ Are you pregnant? _______ Nursing? ________

Do you or have you ever experienced the following? (circle, if yes)

Y/N	Abnormal bleeding	Y/N	Cough	Y/N	Glaucoma	Y/N	Kidney problems	Y/N	Steroid therapy
Y/N	Asthma	Y/N	Chicken pox	Y/N	Hay Fever	Y/N	Liver disease	Y/N	Sickle cell
Y/N	Alcohol abuse	Y/N	Chemotherapy	Y/N	Heart attack	Y/N	Low BP	Y/N	Shingles
Y/N	Arthiritis	Y/N	Drug abuse	Y/N	Headaches	Y/N	Lupus	Y/N	Seizures
Y/N	Artificial joints/bones	Y/N	Diabetes	Y/N	Heart murmer	Y/N	MVP	Y/N	Stroke
Y/N	Anemia	Y/N	Difficulty breathing	Y/N	Heart surgery	Y/N	Pacemaker	Y/N	Tuberculosis
Y/N	Artificial valves	Y/N	Epilepsy	Y/N	Hemophelia	Y/N	Psychiatric problem	Y/N	Tonsilitis
Y/N	Blood transfusion	Y/N	Ever hospitalized	Y/N	Herpes I, II	Y/N	Rheumatic fever	Y/N	Thyroid problems
Y/N	Congenital heart defect	Y/N	Emphysema	Y/N	Hepatitis	Y/N	Radiation	Y/N	Ulcers
Y/N	Cancer	Y/N	Fainting spells	Y/N	High BP	Y/N	Scarlet fever	Y/N	Venereal disease
Y/N	Colitis	Y/N	Fever blisters	Y/N	HIV/ AIDS	Y/N	Sinus problems		

Please list any serious medical conditions that you have experienced: ______________________________

____

____

Are you taking any prescription/ over the counter drugs? If yes, please list: ________________________

____

Are you allergic to any of the following? (circle, if yes)

Aspirin Codiene Erythromycin Latex Sedatives Tetracycline

Barbituates Dental Anesthetics Jewelry/ metals Penicillin Sulfa drugs

Please list anything additional that causes an allergic reaction: ____________________________________

Blood Pressure: Initial Visit ______/_______ Date ______/_______

Date ______/_______ Date ______/_______

Date ______/_______ Date ______/_______

Dental History

Are you currently in pain?	Y/N	Previous dentist: ______________________	
If yes, how severe is your pain on a scale of 1-10? _____	Y/N	What was done at that visit: ______________	
Do you require antibiotic before dental treatment?	Y/N	Date of last visit: ______________________	
Do you floss daily?	Y/N	Treatment recommended: _________________	
Brush _______x's / day		Reason for Leaving: ____________________	
Type of bristles on your toothbrush: Soft Med Hard		Would you like fresher breath?	Y/N
Do your gums ever bleed?	Y/N	Whiter teeth?	Y/N
Are your teeth sensitive to cold, heat or anything else?	Y/N	Are you happy with the way your smile looks?	Y/N
Have you ever had Periodontal (gum) disease?	Y/N	If not, what would you change? ______________	
Have you ever had orthodontics?	Y/N	________________________________	

Our office is HIPPA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of in changes in my medical status. I authorize the dental staff to perform the necessary services I may need.

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(Signature) (Date)