

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 this form completely. The better we communicate, the better we can care for you.



ABOUT YOU

Today's Date: _____
E-mail address: _____
Name: _____
I prefer to be called: _____
Male ___ Female ___
Birthdate: ___/___/___ Age: ___
SS#: ___-___-___
Home Address: _____
State: ___ ZIP: _____
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: _____
Last visit date: _____



SPOUSE INFORMATION

His/her name: _____
Employer: _____
Wk #: (___)___-___ Ext: ___
SS #: ___-___-___



INSURANCE COVERAGE

Primary

Dental Coverage: Yes: ___ No: ___
Insurance Co. Name: _____
Insurance Co. Address: _____

Insurance Co. Ph #: (___)___-___
Group # (plan/policy): _____
Insured's Name: _____
Insured's Birthdate: ___/___/___
Insured's Employer: _____
Insured's SS #: ___-___-___

Secondary

Dental Coverage: Yes: ___ No: ___
Insurance Co. Name: _____
Insurance Co. Address: _____

Insurance Co. Ph #: (___)___-___
Group # (plan/policy): _____
Insured's Name: _____
Insured's Birthdate: ___/___/___
Insured's Employer: _____
Insured's SS #: ___-___-___

In the event of an emergency, is
There someone who lives near you
Who should we contact?

His/her name: _____
Wk #: (___)___-___
Hm #: (___)___-___

Birthdate: __/__/____
Driver's license #: ____ = ____ - ____

Person Responsible for Account: _____
Wk #: (____)-____-____ Ext: _____
Hm #: (____)-____-____
Billing Address: _____
Relation: _____
SS #: ____-____-____
Employer: _____
DL #: _____



MEDICAL HISTORY (CONT):

Your current physical health is:
__Good __Fair __Poor
Are you taking any prescription/over-the-Counter or herbal supplement drugs?
__Yes __No
Please list each one: _____

Have you ever taken Phen-Fen (also known As Redux or Pandimin) __Yes __No
If so, when? _____

For Women: Are you taking birth control pills?
__Yes __No
Are you pregnant? __Yes __No
Week #: _____
Are you nursing? __Yes __No

Have you ever had any of the following problems?

Y N Abnormal bleeding	Y N Hepatitis
Y N Alcohol/drug abuse	Y N Herpes
Y N Anemia	Y N High blood pressure
Y N Arthritis	Y N HIV/AIDS
Y N Artificial bones/joints/valves	Y N Hospitalization
Y N Asthma	Y N Kidney problems
Y N Blood transfusion	Y N Liver disease
Y N Cancer/chemotherapy	Y N Low blood pressure



MEDICAL HISTORY:

Do you have a personal physician?
__Yes __No
Physician's Name: _____
Phone #: (____)-____-____
Date of last visit: _____
Are you currently under the care of a physician? __Yes __No
Please explain: _____



DENTAL HISTORY:

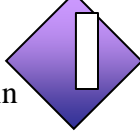
Why have you come to the dentist today? _____

Do you require antibiotics before dental treatment? __Yes __No
Are you currently in pain?
__Yes __No
Do your gums ever bleed?
__Yes __No
Have you ever had a serious/difficult Problem associated with any previous dental work? __Yes __No
Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)?
__Yes __No

- | | |
|-----------------------------|---------------------------|
| Y N Colitis | Y N Mitral Valve Prolapse |
| Y N Congenital Heart Defect | Y N Pacemaker |
| Y N Diabetes | Y N Psychiatric problems |
| Y N Difficulty breathing | Y N Radiation treatment |
| Y N Emphysema | Y N Rheumatic fever |
| Y N Epilepsy | Y N Seizures |
| Y N Fainting spells | Y N Shingles |
| Y N Frequent headaches | Y N Sickle Cell Disease |
| Y N Glaucoma | Y N Sinus problems |
| Y N Hay fever | Y N Stroke |
| Y N Heart attack | Y N Thyroid problems |
| Y N Heart murmur | Y N Tuberculosis |
| Y N Heart surgery | Y N Uclers |
| Y N Hemophelia | Y N Venereal Disease |

Are you allergic to any of the following?

- | | |
|------------------------|------------------|
| Y N Aspirin | Y N Erythromycin |
| Y N Codeine | Y N Metals |
| Y N Jewelry | Y N Penicillin |
| Y N Dental Anesthetics | |
| Y N Latex | |
| Y N Tetracycline | |



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 confidence 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 that I may need during diagnosis and treatment with my informed consent.

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

Signature	Date
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 paying any co-payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

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

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein.

Initials: _____ Date: _____

Doctor's comments:

	Medical History Update:	
1. Date:	Comments:	Signature:
2. Date:	Comments:	Signature:
3. Date:	Comments:	Signature:
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