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.

1 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:_____

2 SPOUSE INFORMATIION

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

3 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 #:_____

4 MEDICAL HISTORY:

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

4 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

5 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

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	HID/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

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			

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

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.

_____
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

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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