WELCOME

1 ABOUT YOU

Today's Date: _____/_____/_____

Patient Name: _____
LAST FIRST MI

What You Prefer To Be Called: _____ ❑ Male ❑ Female

Birthdate: _____/_____/_____ Age: _____

Mailing Address: _____

_____
CITY STATE ZIP

Home Phone #: (_____) _____

Work Phone #: (_____) _____ Ext: _____

Cell Phone #: (_____) _____

E-mail Address: _____

Referred By: _____

Employer: _____ How Long? _____

Occupation: _____

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name _____

Do you have children? ❑ Yes ❑ No How many? _____

2 EMERGENCY CONTACT

Whom should we contact? _____

Relation: _____

Home Phone #: (_____) _____

Work Phone #: (_____) _____

Cell Phone #: (_____) _____

Who is your Medical Doctor? _____

Medical Doctor's Phone #: (_____) _____

3 ACCOUNT INFO

Person ultimately responsible for account

Name: _____

Relation: _____

Our office requires payment in full for all services rendered at the time of visit.
Cash, Checks and all Major Credit Cards accepted.

4 INSURANCE INFO

Please bring dental insurance card

5 DENTAL INFORMATION

Reason for today's visit: ❑ Exam ❑ Emergency ❑ Consultation Are you in pain? ❑ No ❑ Yes How Long? _____

Please indicate ☑ any of the following problems:

❑ Discomfort, clicking or popping in jaw	❑ Lost/Broken Filling(s)	❑ Stained teeth	❑ Broken/Chipped tooth
❑ Blisters/Sores in or around the mouth	❑ Teeth grinding	❑ Locking jaw	❑ Sensitive tooth, teeth or gums
❑ Red, swollen or bleeding gums	❑ Ringing in Ears	❑ Bad breath	❑ Active Decay/Cavity(ies)

❑ Other: _____

Do you require pre-medication? ❑ Yes ❑ No ❑ Don't know Have you ever been treated for Gum Disease? ❑ Yes ❑ No

Previous Dentist: _____ (_____) _____
Name Address Phone #

Last Dental Exam: _____/_____/_____ Last Dental X-rays: _____/_____/_____ Last Dental Cleaning _____/_____/_____

Have you had problems with previous dental treatment? If so, explain: _____

Times a day you brush? _____ Times a week you floss? _____ Type of tooth brush bristles? ❑ Soft ❑ Medium ❑ Hard

Rate your Smile from 1 - 10: ____ Excellent = 10 Would you like whiter teeth ❑ Y ❑ N Have you had orthodontic treatment? ❑ Y ❑ N

Things you would change about your smile? _____

CONTINUE ON BACK

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now other than your primary? ❑ Yes ❑ No If yes_____

Have you ever been hospitalized or had a major operation? ❑ Yes ❑ No If yes_____

Have you ever had a serious head or neck injury? ❑ Yes ❑ No If yes_____

Are you taking any medications? ❑ Yes ❑ No If yes_____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ❑ Yes ❑ No If yes_____

Do you use tobacco? ❑ Yes ❑ No

Are you allergic to any of the following?

❑ Aspirin	❑ Penicillin	❑ Codeine	❑ Acrylic
❑ Metal	❑ Latex	❑ Sulfa drugs	❑ Local Anesthetics

Women: Are you...

❑ Pregnant/Trying to get pregnant? ❑ Nursing? ❑ Taking oral contraceptives?

Do you have, or have you had, any of the following?

AIDS/HIV Positive	❑ Yes ❑ No	Cancer	❑ Yes ❑ No	Heart-Mitral Valve Prolapse	❑ Yes ❑ No
Alzheimer/Dementia	❑ Yes ❑ No	Chest Pains	❑ Yes ❑ No	Hepatitis B or C	❑ Yes ❑ No
Anaphylaxis	❑ Yes ❑ No	Cold Sores/Fever Blisters	❑ Yes ❑ No	Jaw Joint-Pain	❑ Yes ❑ No
Angina	❑ Yes ❑ No	Diabetes	❑ Yes ❑ No	Liver Disease	❑ Yes ❑ No
Artificial Heart Valve	❑ Yes ❑ No	Dry Mouth	❑ Yes ❑ No	Lung Disease	❑ Yes ❑ No
Artificial Joint	❑ Yes ❑ No	Epilepsy or Seizures	❑ Yes ❑ No	Osteoporosis	❑ Yes ❑ No
Asthma	❑ Yes ❑ No	Fainting Spells/Dizziness	❑ Yes ❑ No	Premed Needed	❑ Yes ❑ No
Bleeding-Excessive	❑ Yes ❑ No	Headaches-Frequent	❑ Yes ❑ No	Rheumatic Fever	❑ Yes ❑ No
Blood Disease	❑ Yes ❑ No	Heart Attack/Failure	❑ Yes ❑ No	Sleep Apnea	❑ Yes ❑ No
Blood Pressure-High	❑ Yes ❑ No	Heart-Congenital Disorder	❑ Yes ❑ No	Stroke	❑ Yes ❑ No
Blood Pressure-Low	❑ Yes ❑ No	Heart Pacemaker	❑ Yes ❑ No	Tuberculosis	❑ Yes ❑ No
Blood Thinners	❑ Yes ❑ No	Heart Trouble/Disease	❑ Yes ❑ No		
Breathing Problems	❑ Yes ❑ No	Heartbeat-Irregular	❑ Yes ❑ No		

Have you ever had any serious illness not listed? ❑ Yes ❑ No If yes _____

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims, if necessary.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

_____ **I acknowledge that I have received a copy of the Summary of Privacy Notice.**
Initials

Signature _____ **Date** ____/____/____

❑ Adult Patient ❑ Parent or Guardian ❑ Spouse