

# Welcome

## ABOUT YOU

Today's Date: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

**Name:** \_\_\_\_\_ I prefer to be called: \_\_\_\_\_  Male  Female  
Last First Mi Mr Mrs Ms Dr

Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Social Security #: \_\_\_\_\_  Single  Married  Divorced  Widowed  Separated

**Home Address:** \_\_\_\_\_  
Street City State Zip

Home Phone #: (\_\_\_\_) \_\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_\_ Work Phone #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ Driver License #: \_\_\_\_\_

Where & when are best times to reach you? \_\_\_\_\_ Whom may we Thank for referring you? \_\_\_\_\_

Other family members seen by us: \_\_\_\_\_

**Employer:** \_\_\_\_\_ How long there? \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer's Address: \_\_\_\_\_  
Street/PO Box City State Zip

### Neighbor or Relative not living with you

His / Her Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Work Phone #: (\_\_\_\_) \_\_\_\_\_ Home Phone #: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

### Person Responsible for Account if other than yourself

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Home Phone #: (\_\_\_\_) \_\_\_\_\_ Social Security #: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ Drivers License #: \_\_\_\_\_

Billing Address: \_\_\_\_\_  
Street City State Zip

## SPOUSE INFORMATION

His / Her Name: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_ Social Security #: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ Drivers License #: \_\_\_\_\_

## INSURANCE INFORMATION

**Primary Insurance** Dental Coverage?  Yes  No Medical Coverage?  Yes  No Orthodontic Coverage?  Yes  No

Insurance Co. Name: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_ Group # (Plan, Local or Policy #): \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_  
Street/PO Box City State Zip

Insured's Name: \_\_\_\_\_ Insured's Social Security #: \_\_\_\_\_ Insured's Birthdate: \_\_\_/\_\_\_/\_\_\_ Relation: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_ Employer's Address: \_\_\_\_\_  
Street/PO Box City State Zip

**Secondary Insurance** Dental Coverage?  Yes  No Medical Coverage?  Yes  No Orthodontic Coverage?  Yes  No

Insurance Co. Name: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_ Group # (Plan, Local or Policy #): \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_  
Street/PO Box City State Zip

Insured's Name: \_\_\_\_\_ Insured's Social Security #: \_\_\_\_\_ Insured's Birthdate: \_\_\_/\_\_\_/\_\_\_ Relation: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_ Employer's Address: \_\_\_\_\_  
Street/PO Box City State Zip

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## DENTAL HISTORY

**Why have you come to the dentist today?** \_\_\_\_\_

- Are you currently in pain?  Yes  No
- Do you require antibiotics before dental treatment?  Yes  No
- Have you experienced problems 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
- Your current dental health is  Good  Fair  Poor
- Do you floss daily?  Yes  No      Brush daily?  Yes  No
- Type of bristles on your toothbrush?  Hard  Medium  Soft
- How long do you use a toothbrush before replacing it? \_\_\_\_\_
- Do you use anything in addition to your brush and floss?  Yes  No
- If yes, what? \_\_\_\_\_
- Would you like fresher breath?  Yes  No      Whiter teeth?  Yes  No

- Do your gums ever bleed?  Yes  No      Ever Itch?  Yes  No
- Have you ever had periodontal disease?  Yes  No
- Do you have mobility in your teeth?  Yes  No
- Are your teeth sensitive to heat, cold, or anything else? \_\_\_\_\_
- Do you still have wisdom teeth?  Yes  No
- If yes, why? \_\_\_\_\_

Previous / Present Dentist: \_\_\_\_\_ last Visit Date: \_\_\_\_\_  
(Please Circle)

Why did you leave your previous dentist? \_\_\_\_\_

What did you like most & least about any dentist you have seen? \_\_\_\_\_

**Are you happy with the way your smile looks?**  Yes  No

If not, what would you change? \_\_\_\_\_

## MEDICAL HISTORY

Do you have a personal physician?  Yes  No      Date of last visit: \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

**Your current physical health is:**  Good  Fair  Poor

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

Please explain: \_\_\_\_\_

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

Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath?  Yes  No

Have you ever taken Fosamax, or any other Bisphosphonate?  Yes  No

**Are you allergic to any of the following?**

- |                        |                      |                  |
|------------------------|----------------------|------------------|
| Y N Aspirin            | Y N Erythromycin     | Y N Sedatives    |
| Y N Barbiturates       | Y N Jewelry / Metals | Y N Sulfa Drugs  |
| Y N Codeine            | Y N Latex            | Y N Tetracycline |
| Y N Dental Anesthetics | Y N Penicillin       | Y N Other        |

Please list additional drugs/materials that cause allergic reactions: \_\_\_\_\_

**For Women:** Are you taking birth control pills?  Yes  No

Are you pregnant?  Unsure  Yes  No

Week #: \_\_\_\_\_ Are you nursing?  Yes  No

**Are you taking any of the following?**

- |                    |                                |                            |                      |
|--------------------|--------------------------------|----------------------------|----------------------|
| Y N Acetaminophen  | Y N Blood Thinners             | Y N Insulin/Diabetes Drugs | Y N Thyroid Medicine |
| Y N Antibiotics    | Y N Blood Pressure Medication  | Y N Nitroglycerin          | Y N Tranquilizers    |
| Y N Antihistamines | Y N Cold Remedies              | Y N Recreational Drugs     |                      |
| Y N Aspirin        | Y N Digitalis/Heart Medication | Y N Steroids/Cortisone     |                      |

Are you taking any prescription, over-the-counter drugs, herbal remedies, vitamins or minerals not listed above?  Yes  No If yes, please list each one: \_\_\_\_\_

**Do you or have you experienced the following?**

- |                             |                             |                                 |                                 |                         |
|-----------------------------|-----------------------------|---------------------------------|---------------------------------|-------------------------|
| Y N Abnormal Bleeding       | Y N Colitis                 | Y N Headaches                   | Y N Liver Disease               | Y N Seizures            |
| Y N Alcohol Abuse           | Y N Congenital Heart Defect | Y N Heart Attack                | Y N Low Blood Pressure          | Y N Shingles            |
| Y N Anemia                  | Y N Diabetes                | Y N Heart Murmur                | Y N Lupus                       | Y N Sickle Cell Disease |
| Y N Arthritis               | Y N Difficulty Breathing    | Y N Heart Surgery               | Y N Mitral Valve Prolapse       | Y N Sinus Problems      |
| Y N Artificial Bones/Joints | Y N Drug Abuse              | Y N Hemophilia                  | Y N Osteoporosis/Page's Disease | Y N Steroid Therapy     |
| Y N Artificial Valves       | Y N Emphysema               | Y N Hepatitis                   | Y N Pacemaker                   | Y N Stroke              |
| Y N Asthma                  | Y N Epilepsy                | Y N Herpes                      | Y N Persistent Cough            | Y N Thyroid Problems    |
| Y N Blood Transfusion       | Y N Fainting Spells         | Y N High Blood Pressure         | Y N Psychiatric Treatment       | Y N Tonsillitis         |
| Y N Cancer                  | Y N Fever Blisters          | Y N HIV+/AIDS                   | Y N Radiation Treatment         | Y N Tuberculosis (TB)   |
| Y N Chemotherapy            | Y N Glaucoma                | Y N Hospitalized for Any Reason | Y N Rheumatic Fever             | Y N Ulcers              |
| Y N Chicken Pox             | Y N Hay Fever               | Y N Kidney Problems             | Y N Scarlet Fever               | Y N Venereal Disease    |

Please list any serious medical condition(s) that you have experienced: \_\_\_\_\_

## AUTHORIZATIONS

I affirm that the information I have given is correct to the best of my knowledge. It 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 the necessary dental services I may need. My method of payment will be \_\_\_\_\_.

Signature \_\_\_\_\_ Date \_\_\_\_\_

### PAYMENT IS DUE AT TIME OF SERVICE

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

I certify that I am covered by \_\_\_\_\_ Insurance Co. and I assign directly to Dr. \_\_\_\_\_ all insurance benefits, otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature \_\_\_\_\_ Date \_\_\_\_\_