

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral



health. Please fill out these forms completely. The better we communicate, the better we can care for you.

1 About You
 Today's Date: _____

Name: _____
LAST FIRST MI MR MRS MS DR

I prefer to be called: _____ Male Female

Birthdate: ___/___/___ Age: ___ SS#: _____

Home Address: _____
APT/CONDO #

_____ CITY STATE ZIP

Single Married Divorced Widowed Separated

Home # _____ Pager/other # _____

WK#: _____ Ext: _____ DL#: _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Who may we Thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____
(Please Circle)

Last Visit Date: _____

2 Spouse Information:

Their Name: _____

Employer: _____

WK #: _____ Ext: _____

SS#: _____

Birthdate: ___/___/___ DL# _____

Person Responsible for Account: _____

WK #: _____ Ext: _____ HM #: _____

Billing Address: _____

Relationship: _____

SS# _____ DL# _____

Employer: _____

3 Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone#: _____

Group # (plan, Local, or Policy #): _____

Insured's Name: _____

Insured's Birthday: ___/___/___ Relation: _____

Insured's SS#: _____

Insured's Employer: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone#: _____

Group # (plan, Local, or Policy #): _____

Insured's Name: _____

Insured's Birthday: ___/___/___ Relation: _____

Insured's SS#: _____

Insured's Employer: _____

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

Their Name: _____ Relation: _____

HM#: _____ WK#: _____

4 Medical History

Do you have a personal physician? No Yes

Physician's Name: _____

Phone #: _____ Date of last visit: _____

CONTINUED ON BACK OF FORM

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Medical History continued

Your current physical health is: Good Fair Poor

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

Please explain _____

Are you taking any prescription/over-the-counter drugs?

No Yes

Please list each one _____

For Women

Are you taking birth control pills? No Yes

Are you pregnant? No Yes Week# _____

Are you nursing? No Yes

Have you ever had any of the following diseases or medical problems?

- | | |
|-------------------------------|---------------------------------------|
| Y N Heart Attack /Stroke | Y N Psychiatric Problems |
| Y N Cancer /Chemotherapy | Y N Epilepsy/Seizures/Fainting Spells |
| Y N Heart Murmur | Y N Diabetes/Tuberculosis (TB) |
| Y N Rheumatic Fever | Y N Drug/Alcohol Abuse |
| Y N HIV+/AIDS | Y N Venereal Disease |
| Y N Heart Surgery/Pacemaker | Y N Hemophilia/Abnormal Bleeding |
| Y N Shingles | Y N Ulcers/Colitis |
| Y N Mitral Valve Prolapse | Y N Congenital Heart Defect |
| Y N Kidney Problems | Y N Anemia/Radiation Treatment |
| Y N Artificial Bones/Joints | Y N Asthma/Arthritis |
| Y N Artificial Valves | Y N Difficulty Breathing |
| Y N Sinus Problems | Y N Hospitalized for Any Reason |
| Y N High/Low Blood Pressure | Y N Hepatitis |
| Y N Fever Blisters | Y N Blood Transfusion |
| Y N Severe/Frequent Headaches | Y N Emphysema/Glaucoma |

Please list any serious medical condition(s) that you have ever had:

Are you allergic to any of the following drugs?

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

Please (1st any other drugs that you are allergic to: _____

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Dental History

Why have you come to the dentist today? _____

Are you currently in pain? No Yes

Have you ever had a serious/difficult problem associated any previous dental work? No Yes

Do you now or have you ever experienced pain / discomfort in your Jaw Joint (TMJ / TMD)? No Yes

Your current dental health is: Good Fair Poor

Do you like your smile? No Yes

Do your gums ever bleed? No Yes

How many times a week do you floss? ___ a day do you brush? ___

Type of bristles? Hard Medium Soft

I 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 statue. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

Signature _____

Date _____

Payment is due in full at the time of treatment unless prior arrangements have been approved.

Thank you for filling out this form completely. It will enable us to help you more efficiently. If you have any questions at any time, please ask us. We are happy to help.

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

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

I verbally reviewed the medical dental information above with the parent patient named herein. Initials: _____ Date: _____

Doctor's Comments: _____

Medical History Update

1. Date: _____ Comments: _____ Signature: _____

2. Date: _____ Comments: _____ Signature: _____

3. Date: _____ Comments: _____ Signature: _____