

# Welcome!

The benefits of a happy and healthy smile are tremendous!  
The goal of our office is to help you reach and maintain maximum oral health. Please fill out this form in its entirety. The more we know about you, the better we can serve you and your family.

## ABOUT YOU, OUR PATIENT

Date \_\_\_\_\_

Name \_\_\_\_\_  male  female SSN \_\_\_\_\_ Age \_\_\_\_\_

I prefer to be called \_\_\_\_\_ DOB- \_\_\_\_/\_\_\_\_/\_\_\_\_  Single  Married  Divorced  Widowed  Separated

Home address \_\_\_\_\_  
(street) (city) (state) (zip)

Hm# \_\_\_\_\_ Wk# \_\_\_\_\_ Ext# \_\_\_\_\_ Cell# \_\_\_\_\_

Email address \_\_\_\_\_ DL# \_\_\_\_\_

When and where is the best time to reach you? \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_ How long at present position? \_\_\_\_\_

Employer's Address \_\_\_\_\_  
(street) (city) (state) (zip)

Whom may we thank for referring you to us? \_\_\_\_\_

## SPOUSE/PARENT INFO

His/Her name \_\_\_\_\_ Employer \_\_\_\_\_ Wk# \_\_\_\_\_

SSN \_\_\_\_\_ DL# \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Person responsible for account \_\_\_\_\_ Relationship \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

If different from above: Billing address \_\_\_\_\_  
(street) (city) (state) (zip)

Hm# \_\_\_\_\_ Wk# \_\_\_\_\_ Ext# \_\_\_\_\_ SSN \_\_\_\_\_

## DENTAL INSURANCE INFO

### PRIMARY INSURANCE

Insurance Co. name \_\_\_\_\_ Insurance Co. phone# \_\_\_\_\_ Policy# \_\_\_\_\_

Insurance billing address \_\_\_\_\_

Insured's name \_\_\_\_\_ Relation \_\_\_\_\_ SSN \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

### SECONDARY INSURANCE

Insurance Co. name \_\_\_\_\_ Insurance Co. phone# \_\_\_\_\_ Policy# \_\_\_\_\_

Insurance billing address \_\_\_\_\_

Insured's name \_\_\_\_\_ Relation \_\_\_\_\_ SSN \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

In the event of an emergency, is there someone that we may contact?

Name \_\_\_\_\_ Relation \_\_\_\_\_ Hm# \_\_\_\_\_ Wk# \_\_\_\_\_

## MEDICAL HISTORY

Do you have a personal physician?  yes  no Physician's name \_\_\_\_\_ Ph# \_\_\_\_\_  
 Date of last visit \_\_\_\_\_ Your current health is  good?  fair?  poor?  
 Are you taking any prescription/herbal or homeopathic drugs.  no  yes, please list \_\_\_\_\_

### Do you or have you ever experienced any of the following?

Y N Anemia / excess bleeding Y N Artificial bones / joints Y N Artificial heart valves Y N Arthritis Y N Asthma Y N Blood transfusion Y N Cancer Y N Chemo-radiation therapy Y N Congenital heart defect Y N Diabetes Y N Difficulty breathing Y N Drug / alcohol problem	Y N Emphysema Y N Epilepsy / seizures Y N Fever blisters Y N Heart surgery / pacemaker Y N High / low blood pressure Y N Heart attack / when ? _____ Y N Heart murmur Y N Hepatitis Type _____ Y N Herpes Y N HIV+ / AIDS Y N Migraines Y N Mitral valve prolapse	Y N Rheumatic fever Y N Scarlet fever Y N Severe headaches Y N Shingles Y N Sinus trouble Y N Stroke Y N Synthroid for thyroid Y N Tuberculosis (TB) Y N Ulcers Y N Venereal Disease Other _____
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#### Are you allergic to any of the following?

Aspirin  Codeine  Dental Anesthetics  Erythromycin  
 Latex  Penicillin  Sulfa Drugs  Tetracycline  
 Other \_\_\_\_\_  
 Have you ever taken antibiotics prior to a dental procedure?  
 no  yes, explain \_\_\_\_\_

#### Women

Are you pregnant?  no  yes, due date \_\_\_\_\_  
 Are you taking Birth Control Pills  yes  no  
 Are you nursing?  yes  no

## DENTAL HISTORY

Why have you come to the dentist today? \_\_\_\_\_  
 Do you like your smile?  yes  no  
 If you could change anything about your teeth, what would it be? \_\_\_\_\_  
 Do your gums bleed?  yes  no  
 How many times do you brush a day? \_\_\_\_\_ floss a week? \_\_\_\_\_  
 Are you currently in pain?  yes  no

Does your jaw  click?  pop?  hurt?  lock?  
 Have you ever had difficulties following a dental procedure?  
 no  yes, explain \_\_\_\_\_  
 Have you ever had periodontal (gum) disease?  yes  no  
 Are any of your teeth loose?  yes  no  
 Are your teeth sensitive to  hot?  cold?  sweets?

The information that I have given on this questionnaire is correct to the best of my knowledge. I understand that it is my responsibility to notify the office of any changes in my medical history. I also understand that all information given is to be held in the strictest confidence.

\_\_\_\_\_  
(signature)

\_\_\_\_\_  
(date)

I understand that I am responsible for payment for services rendered, AND I am responsible for deductibles and remaining balances that my insurance carrier does not cover.

\_\_\_\_\_  
(signature)

\_\_\_\_\_  
(date)

### Annual Medical History Update (Sign and Date)

I have reviewed my medical history and made all the changes necessary. \_\_\_\_\_  
 I have reviewed my medical history and made all the changes necessary. \_\_\_\_\_  
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