

# 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:** \_\_\_\_\_

Home Phone #: (\_\_\_\_) \_\_\_\_\_ Street City State Zip  
Cell/other #: (\_\_\_\_) \_\_\_\_\_ Work Phone #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ Driver's 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

## Spouse Information

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

Employer: \_\_\_\_\_ Work Phone #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

## Insurance Information

**Primary Insurance** Dental Coverage?  Yes  No Orthodontic Coverage?  Yes  No Medical 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 Orthodontic Coverage?  Yes  No Medical 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
- 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
- Do your gums ever bleed?  Yes  No      Ever Itch?  Yes  No
- Have you ever had periodontal disease?  Yes  No

Are your teeth sensitive to heat, cold, or anything else? \_\_\_\_\_

- Do you have mobility in your teeth?  Yes  No
- Do you still have wisdom teeth?  Yes  No
- Previous / Present Dentist: \_\_\_\_\_ Last Visit Date: \_\_\_\_\_  
(Please Circle)
- Would you like fresher breath?  Yes  No      Whiter teeth?  Yes  No
- 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
- Physician's Name: \_\_\_\_\_
- Address: \_\_\_\_\_  
Street
- City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
- Phone #: (\_\_\_\_) \_\_\_\_\_ Date of last visit: \_\_\_\_\_
- 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 ever taken Fosamax or any other bisphosphonate?  Yes  No
- For Women:** Are you taking birth control pills?  Yes  No
- Are you pregnant?  Unsure  Yes  No
- Week #: \_\_\_\_\_ Are you nursing?  Yes  No

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

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

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

Are you taking any prescription/over the counter drugs?  Yes  No      If yes, please list each one: \_\_\_\_\_

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

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

Please list anything additional that causes allergic reactions: \_\_\_\_\_

## Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need. I assign the Doctor all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover. I have received a copy of this offices Notice of Privacy Practices.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date