About You

Today's Date:
E-mail Address:
Last Name:
First Name: MI: Mr Mrs Ms Dr
I prefer to be called: Male Female
Birthdate: / / Age:
SS#:
Home Address:
CITY STATE ZIP
Single Married Divorced Widowed Separated
Hm #: () Cell #: ()
Wk #: () Ext DL #:
Employer:
How long there? Occupation:
Where & when are best times to reach you?
Whom may we Thank for referring you?
Other family members seen by us:
Previous / Present Dentist:
Last Visit Date:



His / Her Name:					
Employer:					
Cell #: ()	SS #:				
Birthdate:/ Driver's License#:					
Person Responsible for Account:					
Cell #: ()	Hm #: ()				
Billing Address:					
Relation:	SS #:				
Employer:	DL #:				

DENTAL CARE DENTAL CARE DENTAL CARE DENTAL CARE DENTAL CARE Primary Primary Primary Primary Dental Coverage: \Ves \No

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

Insurance Co. Name: _____

Insured's Birthday: / /

Insured's Name:

Insured's SS #:

Insurance Co. Phone #: (______)

His / Her Name:		
Relation:		
Cell #: () Hm #: ()	
4 Medical E	listc	ory
Do you have a personal physician?	yes	No
Physician's Name:		
Phone #: () Date of last visit:		
Are you currently under the care of a physician?	yes	No
Please explain:		

Medica	History continued

Your c	urrent physical health is:	Good	🗌 Fair	Poor
Are yo	ou taking any prescription/ over-t	he-counter	or herbal suppleme	nt drugs?
	• • • •	Yes	No	· ·
Please	list each one:			
Have v	ou ever taken Fosamax, or any o	ther bispho	osphonate? 🗌 Yes	No
Have y	ou ever taken Phen-fen?	Yes	No	
For Wo	men: Are you using a prescribed r	nethod of bi	irth control? 🗌 Yes	No
Are yo	ou pregnant? Yes	No No	Week #:	
Are yo	ou nursing?	No		
Ha	ave you ever had any of the follo	owing disea	ses or medical prot	olems?
Y N	Abnormal Bleeding	Y N	Hepatitis	
Y N	Alcohol / Drug Abuse	У М	Herpes / Fever Blis	ters
Y N	Anemia	Y N	High Blood Pressu	re
Y N	Arthritis	Y N	HIV+ / AIDS	
Y N	Artificial Bones / Joints / Valves	УМ	Hospitalized for an	ny reason
Y N	Asthma	УN	Kidney Problems	
Y N	Blood Transfusion	УМ	Liver Disease	
Y N	Cancer / Chemotherapy	Y N	Low Blood Pressur	e
Y N	Colitis	УМ	Mitral Valve Prolaps	se
Y N	Congenital Heart Defect	УМ	Pacemaker	
V N	Diabetes	Y N	Psychiatric Problem	ns

У	Ν	Congenital Heart Defect	У	Ν	Pacemaker
У	Ν	Diabetes	У	Ν	Psychiatric Problems
У	Ν	Difficulty Breathing	У	Ν	Radiation Treatment
У	Ν	Emphysema	У	Ν	Rheumatic / Scarlet Fever
У	Ν	Epilepsy	У	Ν	Seizures
У	Ν	Fainting Spells	У	Ν	Shingles
У	Ν	Frequent Headaches	У	Ν	Sickle Cell Disease / Traits
У	Ν	Glaucoma	У	Ν	Sinus Problems
У	Ν	Hay Fever	У	Ν	Stroke
У	Ν	Heart Attack	У	Ν	Thyroid Problems
у	Ν	Heart Murmur	У	Ν	Tuberculosis (TB)
у	Ν	Heart Surgery	У	Ν	Ulcers
у	Ν	Hemophilia	У	Ν	Venereal Disease

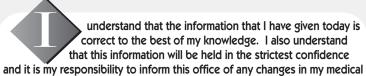
Please list any serious medical condition(s) that you have ever had:

Are you allergic to any of the following? Erythromycin N Aspirin Y N Y N Metals Codeine Jewelry y Penicillin N Y N N **Dental Anesthetics** Y N Latex У Ν Tetracycline N Please list any other drugs/materials that you are allergic to:

Dental History

Why have you come to the dentist today?

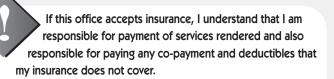
Do you require antibiotics before dental treatment?	Yes	No
Are you currently in pain?	Yes	No
Do your gums ever bleed?	Yes	No
Have you ever had a serious / difficult problem associated with any previous dental work?	yes	No
Do you now or have you ever experienced pain/ discomfort in your jaw joint (TMJ / TMD)?	yes	No
Your current dental health is: Good Fair	Poor	
Do you like your smile?	Yes	No
Would you like whiter teeth? $\$ Yes $\$ $\$ No $\$ Fresher breath	n? Ves	No
How many times a week do you floss? a day do	you brush	?
Type of bristles? Soft Medium Hard		
Do you smoke or use tobacco in any other form?	Yes	No



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

Signature

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



Date

Date

Signature

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

OFFICE USE ONLY • OFFICE USE ONLY • **OFFICE USE ONLY •** OFFICE USE ONLY

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

Date: