Welcome

Please fill out both sides of this form completely. The more we know about you the better we can care for you.

1 About You...

Todays date _____

Soc. Sec. # _____

Lic./I.D. # _____

Name _____
Last First Middle

Address _____
Street Address Unit No.

_____
City State Zip

Birthdate _____ Age ____ ☐ Male ☐ Female

Referred By _____

Occupation _____

Employer _____

Emp. Adress _____

Home Phone _____

Cell Phone _____

E- mail _____

Best day and time to reach you: _____

2 Spouse/Guardian...

Soc. Sec. # _____

Lic./I.D. # _____

Name _____

Birthdate _____

Occupation _____

Employer _____

Emp. Address _____

_____

_____

3 Primary Insurance...

Company _____

Group # _____

Co. Tel. # _____

Insured's Name _____

Relationship _____

Insured's SS# _____

Insured's Birthday _____

Insured's Employer _____

Employer Tel. # _____

Employer Address _____

_____

_____

_____

4 Secondary Insurance...

Company _____

Group # _____

Co. Tel. # _____

Insured's Name _____

Relationship _____

Insured's SS# _____

Insured's Birthday _____

Insured's Employer _____

Employer Tel. # _____

Employer Address _____

_____

_____

_____

(Continued on reverse)

Medical History

Your Physical health is: Good Fair Poor

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

Pyhsician Name: _____

Physician Phone: _____

Do you smoke or use tobacco? Yes Nc

Are you taking any drugs? Yes No

If yes, please list each one:

For Women

Are you taking birth control pills? Yes No Week#: _____

Are you nursing? Yes No

Are you pregnant? Yes No

Have you ever had any of the following?
Please check all that apply:

Yes	No		Yes	No	
☐	☐	Anemia/Radiation Therapy	☐	☐	Heart Surgery/Pacemaker
☐	☐	Artificial Bones/Joints	☐	☐	Hemophilia/Abnormal Bleeding
☐	☐	Artificial Valves	☐	☐	Hepititis
☐	☐	Asthma/Arthritis	☐	☐	High/Low Blood Presure
☐	☐	Blood Transfusion	☐	☐	HIV+/AIDS
☐	☐	Cancer/Chemotherapy	☐	☐	Hospitalization for any reason
☐	☐	Congenial Heart Defest	☐	☐	Kidney Problems
☐	☐	Diabetes/Tuberculosis (TB)	☐	☐	Mitral Valve Prolapse
☐	☐	Difficulty Breathing	☐	☐	Psychiartic Problems
☐	☐	Drug/Alcohol Abuse	☐	☐	Rheumatic/Scarlet Fever
☐	☐	Emphysema/Glaucoma	☐	☐	Severe/Frequent Headaches
☐	☐	Epilepsy/Seizures/Fainting Spells	☐	☐	Shingles
☐	☐	Fever Blisters/Herpes	☐	☐	Sinus Problems
☐	☐	Heart Attack/Stroke	☐	☐	Ulcers/Colitis
☐	☐	Heart Murmer	☐	☐	Venereal Disease
☐	☐	Have you ever been pre-medicated for dental treatment?	☐	☐	Diet Program/Phen-Phen

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

_____

Are you allergic to any of the following:

☐ Aspirin ☐ Erythromycin ☐ Tetracycline
☐ Codine ☐ Latex ☐ Other
☐ Dental Anesthetics ☐ Penicillin

Please list any other drugs that you are allergic to:

_____

Dental History

Previous/Present Dentist: _____

Date of Last Visit: _____

Why have you come to see us today?: _____

_____

Is your current dental health: Good Fair Poor

Are you currently in pain: Yes No

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

Have you ever had gum treatment? Yes No

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

Do you like your smile? Yes No

Do your gums ever bleed? Yes No

How many times a week do you floss? _____

How many times a day do you brush? _____

Type of tooth brush used? Hard Medium Soft

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

_____

Doctor's Comments

_____

_____

_____

Dr. Signature _____

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 strict confidence and it is my responsibility to inform this office of any changes in my medical status.

I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductibles that my insurance company does not cover.

X _____

In case of emergency, who should we notify:

Name: _____ Relationship: _____

Hm. Phone: _____ Wk. Phone: _____

Medical Hostory Update:

_____

Date Comments Signature

_____

Date Comments Signature