

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

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 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: \_\_\_\_\_

Have you been told that you snore or hold your  
 breath while sleeping or wake gasping for breath?  Yes  No  
 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 Glaucoma	Y N Kidney Problems	Y N Seizures
Y N Alcohol Abuse	Y N Congenital Heart Defect	Y N Hay Fever	Y N Liver Disease	Y N Shingles
Y N Anemia	Y N Diabetes	Y N Headaches	Y N Low Blood Pressure	Y N Sickle Cell Disease
Y N Arthritis	Y N Difficulty Breathing	Y N Heart Attack	Y N Lupus	Y N Sinus Problems
Y N Artificial Bones/Joints	Y N Drug Abuse	Y N Heart Murmur	Y N Mitral Valve Prolapse	Y N Steroid Therapy
Y N Artificial Valves	Y N Emphysema	Y N Heart Surgery	Y N Pacemaker	Y N Stroke
Y N Asthma	Y N Epilepsy	Y N Hemophilia	Y N Persistent Cough	Y N Thyroid Problems
Y N Blood Transfusion	Y N Ever Hospitalized	Y N Hepatitis	Y N Psychiatric Problems	Y N Tonsillitis
Y N Cancer	Y N Fainting Spells	Y N Herpes	Y N Radiation Treatment	Y N Tuberculosis (TB)
Y N Chemotherapy	Y N Fever Blisters	Y N High Blood Pressure	Y N Rheumatic Fever	Y N Ulcers
Y N Chicken Pox		Y N HIV <sup>+</sup> /AIDS	Y N Scarlet Fever	Y N Venereal Disease

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 \_\_\_\_\_