

WELCOME!

The benefits of a Happy, Healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please complete the following information in full so that we can better care for you. Be sure to complete the medical history information on the backside of this questionnaire.

ABOUT YOU:

NAME: _____

HOME ADDRESS: _____

HOME PHONE: _____

WORK PHONE: _____

CELL PHONE: _____

E-MAIL ADDRESS: _____

SS#: _____ - _____ - _____

DOB: ____ / ____ / ____ AGE ____

MARITAL STATUS: _____

EMPLOYER NAME: _____

EMPLOYER ADDRESS: _____

OCCUPATION: _____

SPOUSE INFORMATION:

SPOUSE'S NAME: _____

SPOUSE'S EMPLOYER: _____

SPOUSE'S SS#: _____

SPOUSE'S DOB: _____

DENTAL INSURANCE INFORMATION:

SUBSCRIBER NAME: _____

RELATION TO PATIENT: _____

SUBSCRIBER ID OR SS#: _____

SUBSCRIBER DOB: _____

INSURED EMPLOYER NAME: _____

INSURANCE COMPANY NAME AND ADDRESS: ____

GROUP #: _____

DO YOU HAVE SECONDARY INSURANCE COVERAGE?

YES NO

DENTAL HISTORY:

Why have you come to the dentist today? _____

Do you require antibiotics before dental treatment?

YES NO

Have you experienced problems associated with any previous dental work?

YES NO

How would you describe your current dental health?

GOOD FAIR POOR

Do you brush daily?

YES NO

Do you floss daily?

YES NO

Do your gums bleed?

YES NO

Would you like fresher breath?

YES NO

Would you like whiter teeth?

YES NO

Are you happy with the way your smile looks?

YES NO

Do you now or have you ever experienced discomfort in your jaw joint?

YES NO

WHERE DID YOU HEAR ABOUT US?
(CHECK AS MANY AS APPLY)

Insurance Provider List Phone Book

IN Community Magazine Television

Internet Search

Patient Referral: patient name _____

Other: _____

TODAYS DATE: _____

****Please note that this form continues below...*

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you currently under a physicians care? YES NO N/A _____

Have you ever been hospitalized or had a major operation? YES NO N/A _____

Have you ever had a serious head or neck injury? YES NO N/A _____

Physicians Name:	Physicians Phone:
Pharmacy Name:	Pharmacy Phone:

Please answer the following:

Do you smoke or use tobacco? YES NO

Are you currently on medication? YES NO

If yes, please list the medications you are taking: _____

If you are female:

Are you taking birth control Pills? YES NO

Are you pregnant? YES NO

If yes, # of weeks _____

Are you nursing? YES NO

<p>Allergies</p> <p>Aspirin <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Codeine <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Dental Anesthetics <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Erythromycin <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Jewelry <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Latex <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>Allergies</p> <p>Metals <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Penicillin <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Tetracycline <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Other:</p> <p>_____</p> <p>_____</p>
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Conditions:	Yes	No	Conditions:	Yes	No	Conditions:	Yes	No
AIDS/HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatments	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's disease	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Shingles	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack/Failure	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis/Gout	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pace Maker	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joint	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble/Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Breathing Problem	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B or C	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Yellow Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Cancer-Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Hives or Rash	<input type="checkbox"/>	<input type="checkbox"/>			
Cold Sores/Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>			
Congenital Heart Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>			
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>			

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 the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform and necessary dental services that I may need during diagnosis and treatment with my informed consent. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

Patient Signature: _____

Date: _____