The benefits of a happy health smile are immeasurable? Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

ABOUT YOU

Today's Date:________________________________

Email Address:________________________________

Name:____

I prefer to be called: ______ Male ______ Female

Birthdate:______________ Age:_____ SS#:____________

Home Address:________________________________

Marital Status:________________________________

Hm #:__________________ Cell #:__________________

Wk #:___________________ Ext:__________

Employer:____________________________________

Whom may we thank for referring you?______________

Other family members seen by us:___________________

Previous/Present Dentist:_________________________

Last Visit Date:_______________________________

SPOUSE INFORMATION

His/Her Name:________________________________

Employer:____________________________________

Wk #:___________________ Ext:________

Birthdate:________________ SS#:___________________

Person Responsible for Account:____________________

Wk #:______________Ext:______ Home #:_____________

Billing Address:________________________________

Relationship:__________________ SS#:________________

Employer:____________________________________

PRIMARY INSURANCE

Dental Coverage? ______ Yes ______ No

Insurance Co. Name:______________________________

Insurance Co. Address:____________________________

Insurance Co. Phone #:____________________________

Group # (Plan, Local or Policy #):___________________

Insured's Name:__________________________________

Insured's Birthdate:____________ Relation:____________

Insured's ID#:____________________________________

Insured's Employer:_______________________________

SECONDARY INSURANCE

Dental Coverage? ______ Yes ______ No

Insurance Co. Name:______________________________

Insurance Co. Address:____________________________

Insurance Co. Phone #:____________________________

Group # (Plan, Local or Policy #):___________________

Insured's Name:__________________________________

Insured's Birthdate:____________ Relation: ____________

Insured's ID#:____________________________________

Insured's Employer________________________________

MEDICAL HISTORY

Do you have a personal physician? ______ Yes ______No

Physician's Name:_________________________________

Phone #: _______________________________________

Are you under the care of a physician: _____Yes ____No

Please explain:___________________________________

MEDICAL HISTORY (Continued)

Your Physical Health Is: ____Good ____Fair ____Poor
Do you smoke? ______Yes ______No
Have you had any metal rods, pins or implants? ______Yes ______No
Are you taking any prescription / over the counter or herbal supplements? ______Yes ______No
Please list each one:

Have you ever taken Fosamax, or any other bisphosphonate? ______Yes ______No
Have you ever taken Phen-Fen? ______Yes ______No
FOR WOMEN: Are you using a Prescribed method of birthcontrol? ______Yes ______No
Are you pregnant? ______Yes ______No
Are you nursing? ______Yes ______No

Have you ever had any of the following diseases or medical problems?

_____ Abnormal Bleeding	____ Herpes/Fever Blisters
_____ Alcohol/Drug Abuse	____ High Blood Pressure
_____ Anemia	____ HIV/AIDS
_____ Arthritis	____ Ever Hospitalized
_____ Artificial Bones/Joints/Valves	____ Kidney Problems
_____ Asthma	____ Liver Disease
_____ Blood Transfusion	____ Low Blood Pressure
_____ Cancer/Chemotherapy	____ Lupus
_____ Colitis	____ Mitral Valve Prolapse
_____Congenital Heart Defect	____ Osteoporosis/Paget's
_____ Diabetes	____ Pacemaker
_____ Difficulty Breathing	____ Psychiatric Problems
_____ Emphysema	____ Radiation Treatment
_____ Epilepsy	____ Rheumatic/Scarlet
_____Fainting Spells	____ Seizures
_____ Frequent Headaches	____ Shingles
_____ Glaucoma	____ Sickle Cell Disease
_____ Hay Fever	____ Sinus Problems
_____ Heart Attack	____ Stroke
_____ Heart Murmur	____ Thyroid Problems
_____ Heart Surgery	____ Tuberculosis (TB)
_____ Hemophelia	____ Ulcers
_____ Hepatitis	____ Venereal Disease

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

____

Are you allergic to any of the following?

____ Aspirin	____ Erythromycin	____ Tetracycline
____ Codeine	____ Latex	____ Other
____Dental Anesthetics		____ Penicillin

DENTAL HISTORY

Why have you come to the dentist today?__________________

Do you require antibiotics prior to treatment? ____Yes ____No

Are you currently in pain? _____ Yes _____ No

Have you ever had a serious/difficulties associates with any previous dental work? _____ Yes _____ No

Do you have fears about seeing the dentist? _____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

Your current dental health is: ____ Good ____ Fair ____ Poor

Do you like your smile? _____ Yes _____ No

How many times a week do you floss? ____________________

How many times a day do you brush?_____________________

Type of Bristles? _____ Soft _____ Medium _____ Hard

How long do you use a toothbrush before replacing it?_______

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

Have you lost any teeth? ____ Yes ____ No Why?___________

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 any necessary dental services that I may need during diagnosis and treatment with my informed consent.

____
Signature Date

FOR OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named here in

Initials _________________________ Date____________