Welcome

THANK YOU FOR GIVING US THE OPPORTUNITY TO SERVE YOUR DENTAL NEEDS. PLEASE FILL OUT THIS FORM COMPLETELY.

NAME: ____________________ (LAST) ____________________ (FIRST) ____ (MI)

I PREFER TO BE CALLED: ____________________ ☐ MALE ☐ FEMALE

BIRTHDATE ___/___/___ SS#: ____________________

EMAIL: ____________________

HOME ADDRESS: ____________________ (STREET) ____ (APT NO.)

____________________ (CITY) ____ (STATE) ____ (ZIP)

☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED ☐SEPARATED

HOME # (___) ____________ CELL # (___) ____________

WORK # (___) ____________ DRIVER LIC # ____________

FULL TIME STUDENT? NO YES – SCHOOL ATTENDING: ____________

EMPLOYER: ____________________

EMPLORER'S ADDRESS ____________________ (STREET) ____ (SUITE)

____________________ (CITY) ____ (STATE) ____ (ZIP)

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: ____________________

SPOUSE'S NAME: ____________________

EMPLOYER: ____________________

WORK # (___) ____________ SS#: ____________

BIRTHDATE: ___/___/___ DRIVER LIC # ____________

PERSON RESPONSIBLE FOR ACCOUNT: ☐PATIENT ☐SPOUSE

☐ OTHER: ____________________

WORK # (___) ____________ HOME # (___) ____________

BILLING ADDRESS ____________________ (STREET) ____ (APT #)

____________________ (CITY) ____ (STATE) ____ (ZIP)

RELATION: ____________ SS#: ____________

BIRTHDATE: ___/___/___ DRIVER LIC #: ____________

EMPLOYER: ____________________

TODAY'S DATE ___/___/___

PRIMARY DENTAL INSURANCE

INSURANCE CO. NAME: ____________________

INSURANCE CO. ADDRESS: ____________________

INSURANCE CO. PHONE # (______) ____________________

GROUP # (PLAN, LOCAL OR POLICY#) ____________________

INSURED'S NAME: ____________ RELATION: ________

INSURED'S BIRTHDATE: ___/___/___ INSURED ID# ________

INSURED'S EMPLOYER: ____________________

EMPLOYER'S ADDRESS: ____________________

SECONDARY DENTAL INSURANCE

INSURANCE CO. NAME: ____________________

INSURANCE CO. ADDRESS: ____________________

INSURANCE CO. PHONE # (______) ____________________

GROUP # (PLAN, LOCAL OR POLICY#) ____________________

INSURED'S NAME: ____________ RELATION: ________

INSURED'S BIRTHDATE: ___/___/___ INSURED ID# ________

INSURED'S EMPLOYER: ____________________

EMPLOYER'S ADDRESS: ____________________

IN THE EVENT OF AN EMERGENCY, IS THERE SOMEONE WHO LIVES NEAR YOU THAT WE SHOULD CONTACT?

NAME: ____________________ REALTION: ________

WORK # (___) ____________ HOME # (___) ____________

MEDICAL HISTORY

PHYSICIAN'S NAME: ____________________

WORK # (___) ____________ DATE OF LAST VISIT ________

ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN? ☐ YES ☐ NO

PLEASE EXPLAIN: ____________________

____

Have you ever had any of the following diseases or medical problems? (Please circle the option that applies)

Yes	No	Abnormal Bleeding	Yes	No	HIV+ or AIDS
Yes	No	Alcohol Abuse	Yes	No	Heart Attack
Yes	No	Allergies	Yes	No	Heart Disease
Yes	No	Anemia	Yes	No	Hepatitis
Yes	No	Angina Pectoris	Yes	No	High Blood Pressure
Yes	No	Arthritis	Yes	No	Injury to Head or Face
Yes	No	Artificial Heart	Yes	No	Kidney Problems
Yes	No	Artificial Joints	Yes	No	Liver Disease
Yes	No	Asthma	Yes	No	Low Blood Pressure
Yes	No	Blood Disease	Yes	No	Mitral Valve Prolapse
Yes	No	Breathing Problems	Yes	No	Pacemaker
Yes	No	Cancer-Chemotherapy	Yes	No	Psychiatric Problems
Yes	No	Circulatory Problems	Yes	No	Radiation Therapy
Yes	No	Colitis	Yes	No	Rheumatic Fever
Yes	No	Congenital Heart Disease	Yes	No	Seizures
Yes	No	Cosmetic Surgery	Yes	No	Sexually Trans. Disease
Yes	No	Diabetes	Yes	No	Sinus Problems
Yes	No	Drug Abuse	Yes	No	Sleep Apnea
Yes	No	Emphysema	Yes	No	Stroke
Yes	No	Epilepsy	Yes	No	Thyroid Problems
Yes	No	Fainting Spells	Yes	No	Tuberculosis (TB)
Yes	No	Gastroesophogeal Reflux	Yes	No	Ulcers
Yes	No	Glaucoma			

Please list any serious medical conditions that you have ever had or explain any 'yes' answers from the list above: ____________

____

____

Are you allergic or had an adverse reaction to any of the following?

Yes	No	Aspirin	Yes	No	Jewelry / Metals
Yes	No	Codeine	Yes	No	Latex
Yes	No	Dental Anesthetics	Yes	No	Penicillin
Yes	No	Erythromycin	Yes	No	Tetracycline

Please list any other drugs or materials that you are allergic or have had an adverse reaction to: ____________________________

____

Are you taking any prescription drug, over-the-counter medication, or supplement?

Please list each one: ____________________________

____

____

Yes No Females: Are you pregnant? If so, how many weeks: ________

Yes No Females: Are you nursing?

Your current physical health is (please circle): Good Fair Poor

Yes No Has a physician recommended that you need to take antibiotics before dental treatment?

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 Do you use CPAP or have ever tried to use CPAP?

Yes No Do you snore?

Yes No Do you have High Blood Pressure?

Yes No Has anyone reported that you choke or gasp for air while sleeping?

What is your neck size (in inches)? ____________

Yes No Do you awake refreshed?

Yes No Are you excessively tired during the day?

Yes No Do you get Headaches? If so, please answer the next 6 questions

How often? ____________________________

Has there been a change in your headache pattern? ________

____

Does anything trigger your headaches? ____________

To what degree would you say your headaches effect your life? ___

____

On a scale of one (least) to ten (worst), what is the range of your headaches? ____________________________

Have you been treated or evaluated for your headaches? ________

Dental History

How would you rate your current dental Health? Good Fair Poor

Date of your last dental visit? ____________

Why have you come to the dentist Today? ____________

____

Yes No Are you currently in pain?

Yes No Do your gums ever bleed?

Yes No Are your teeth sensitive to hot, cold, or chewing?

Yes No Have any complication with any previous dental work?

Yes No Have you ever had any head, neck, or jaw injury?

Yes No Ever had orthodontic treatment (braces)?

Yes No Ever had any oral surgery?

Yes No Ever had any periodontal (gum) treatment?

Yes No Ever wear any full or partial denture?

Yes No Ever had any dental implants?

Yes No Are you aware if you clench or grind your teeth?

Yes No Are you presently aware of joint sounds?

Yes No Did you ever have joint sounds?

Yes No Do you ever have pain or soreness in front of your ears?

Yes No Do you have ear pain?

Yes No Do you wake up with your jaws sore or tired?

Yes No Do you ever have difficulty opening widely?

Yes No Do you avoid eating certain foods because of discomfort?

Yes No Have you ever worn a biteguard, splint, or nightguard?

Yes No Would you like to change anything about your smile?

If so, please explain: ____________

How many times a day do you brush your teeth? ____________

How many times a week do you floss? ____________

Is there anything else you want us to know about your medical and dental Health? ____________

____

____

____

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