Welcome

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

NAME: ______ LAST ______ FIRST ______ MI

☐ MALE
☐ FEMALE

I PREFER TO BE CALLED: ______

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