Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Today's Date_____

Name_____ Birthdate_____

Address_____ Apt._____ Soc. Sec. No._____

City_____ State_____ Zip_____ Drivers Lic. No._____

Whom can we thank for referring you?_____

Telephone Information

Home Phone_____ Work Phone_____

Cell Phone_____

When is the best time to call you?_____ And where?_____

In case of emergency, is there someone we can call?

Name_____ Phone_____

About You

I like to be called _____

Occupation_____ Employer_____

City_____ State_____ Zip_____

Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Widowed Spouse's Name_____

If full-time student, name of school_____

Person responsible for this account_____

Address_____ Phone_____

Soc. Sec. No._____ Drivers Lic._____ Relationship to patient_____

Insurance Information

PRIMARY

Ins. Co. Name_____

Insured's Name_____

Soc. Sec. No._____

Birthdate_____

Group No./Rank_____

SECONDARY

Ins. Co. Name_____

Insured's Name_____

Soc. Sec. No._____

Birthdate_____

Group No./Rank_____

Name of Previous Dentist_____ Phone No._____

Address_____ City_____ State_____

Date of Last Dental Visit_____ Purpose_____

Physician's Name_____ Phone No._____

Address_____ City_____ State_____

Medical History

Current Health: ❒ Excellent ❒ Good ❒ Fair ❒ Poor

Are you now or have you been under a physician's care during the last five years? ❒ Yes ❒ No

Have you been hospitalized during the last five years? ❒ Yes ❒ No

Are you currently taking prescription medications? ❒ Yes ❒ No If yes, please list below:

Name of Medication	*Purpose*

Have you had any problems with prolonged bleeding? ❒ Yes ❒ No

Are you subject to any nervous disorders, dizziness, fainting, seizures? ❒ Yes ❒ No

Have you ever had an unexplained weight loss? ❒ Yes ❒ No

Do you smoke or use chewing tobacco? ❒ Yes ❒ No If yes, how much per day?_____

Do you use, or have you ever used (circle): Alcohol Cocaine Other drugs

Are you allergic to, or have you had any reaction to any of the following medications?

Penicillin	❒ Yes	❒ No	Aspirin	❒ Yes	❒ No	Latex	❒ Yes ❒ No
Erythromycin	❒ Yes	❒ No	Codeine	❒ Yes	❒ No		
Tetracycline	❒ Yes	❒ No	Dental Anesthetic	❒ Yes	❒ No		

Have you ever taken Fosamax, Actonel, Boniva or any other biphosphonate? ❒ Yes ❒ No

If yes, please explain_____

Are you allergic to any medications?_____

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

Heart

Heart Failure	❒ Yes	❒ No
Heart Disease or Attack	❒ Yes	❒ No
Irregular heart beat	❒ Yes	❒ No
Angina Pectoris (Chest pain)	❒ Yes	❒ No
Myocardial Infarction	❒ Yes	❒ No
Congenital Heart Disease	❒ Yes	❒ No
Congenital Heart Lesion	❒ Yes	❒ No
Heart Murmur	❒ Yes	❒ No
Mitral Valve Prolapse	❒ Yes	❒ No
Rheumatic Fever	❒ Yes	❒ No
Arteriosclerosis	❒ Yes	❒ No
Heart Pacemaker	❒ Yes	❒ No
Stroke	❒ Yes	❒ No
Fainting Spells	❒ Yes	❒ No
High Blood Pressure	❒ Yes	❒ No
Low Blood Pressure	❒ Yes	❒ No
Heart Surgery (Bypass/Stent)	❒ Yes	❒ No
Damaged Heart Valves	❒ Yes	❒ No
Artificial Heart Valve	❒ Yes	❒ No

Lungs

Emphysema	❒ Yes	❒ No
Chronic Cough	❒ Yes	❒ No
Tuberculosis	❒ Yes	❒ No
Asthma	❒ Yes	❒ No
Bronchitis	❒ Yes	❒ No
Hay fever/Sinus problems	❒ Yes	❒ No
Difficulty breathing	❒ Yes	❒ No
Any lung trouble	❒ Yes	❒ No
Do you smoke?	❒ Yes	❒ No
*How much?	❒ Yes	❒ No
*How long?	❒ Yes	❒ No
Use smokeless tobacco?	❒ Yes	❒ No

Liver

Hepatitis A (infectious)	❒ Yes	❒ No
Hepatitis B (serum)	❒ Yes	❒ No
Hepatitis C	❒ Yes	❒ No
Liver Disease	❒ Yes	❒ No
Yellow Jaundice	❒ Yes	❒ No
Epilepsy or Seizures	❒ Yes	❒ No

Kidney

Kidney Trouble	❒ Yes	❒ No
Kidney Disease	❒ Yes	❒ No
Dialysis treatment	❒ Yes	❒ No

Gastrointestinal

Ulcers	❒ Yes	❒ No
Stomach Problems	❒ Yes	❒ No
Diverticulitis	❒ Yes	❒ No
Bowel problems	❒ Yes	❒ No

Endocrine

Diabetes	❒ Yes	❒ No
Thyroid Problem	❒ Yes	❒ No
Low blood sugar (Hypoglycemia)	❒ Yes	❒ No

Diseases

Cancer	❒ Yes	❒ No
Sexually Trans. Disease	❒ Yes	❒ No
A.I.D.S.	❒ Yes	❒ No
H.I.V. Positive	❒ Yes	❒ No
Cold Sores/Fever Blisters	❒ Yes	❒ No
Other contagious diseases	❒ Yes	❒ No
Glaucoma	❒ Yes	❒ No

Prosthesis

Artificial Joints (hip, knee, etc.)	❒ Yes	❒ No
Surgery Date:		
Implanted plates, screws, pins, etc?	❒ Yes	❒ No
Surgery Date:		
Joint Replacement or Implant	❒ Yes	❒ No

Blood

Blood Transfusion	❒ Yes	❒ No
Hemophilia	❒ Yes	❒ No
Leukemia	❒ Yes	❒ No
Anemia	❒ Yes	❒ No
Sickle Cell Disease	❒ Yes	❒ No
Bruise Easily	❒ Yes	❒ No
Blood Disorder	❒ Yes	❒ No
Abnormal bleeding	❒ Yes	❒ No
Infectious mononucleosis	❒ Yes	❒ No

Other

Sinus Trouble	❒ Yes	❒ No
Cortisone Medicine	❒ Yes	❒ No
Drug Addiction	❒ Yes	❒ No
Radiation Therapy	❒ Yes	❒ No
Chemotherapy	❒ Yes	❒ No
Nervousness	❒ Yes	❒ No
Tumors	❒ Yes	❒ No
Developmentally Disabled	❒ Yes	❒ No
Allergies or Hives	❒ Yes	❒ No
Swollen ankles	❒ Yes	❒ No
Arthritis or joint disease	❒ Yes	❒ No
Delayed healing	❒ Yes	❒ No
Mental Health problems	❒ Yes	❒ No
Alcohol addiction	❒ Yes	❒ No
Severe Headaches	❒ Yes	❒ No
Contact Lenses	❒ Yes	❒ No
Chronic Fatigue	❒ Yes	❒ No
Pain & clicking in jaw joints?	❒ Yes	❒ No
Are you on a diet?	❒ Yes	❒ No
Have you ever been on a Phen Fen diet?	❒ Yes	❒ No

Other_____

FOR WOMEN ONLY: Are you pregnant or think you may be pregnant? ❒ Yes ❒ No

If yes, how many months?_____ Are you taking birth control pills? ❒ Yes ❒ No

Have you ever been treated for TMJ symptoms?	❒ Yes	❒ No	Have you had any orthodontic treatment?	❒ Yes	❒ No
Have you had any head, neck, or jaw injuries?	❒ Yes	❒ No	Have you ever had any difficult extractions?	❒ Yes	❒ No
Do you have frequent headaches?	❒ Yes	❒ No	Have you ever been told that you snore?	❒ Yes	❒ No
Do you clench or grind your teeth?	❒ Yes	❒ No	Do you have any sores or lumps in your mouth?	❒ Yes	❒ No
Have you ever had instructions on the care of your teeth and gums?				❒ Yes	❒ No
Do your gums bleed while brushing or flossing?				❒ Yes	❒ No

How often do you brush your teeth?_____ Floss your teeth?_____

If you could easily and safely whiten your teeth, would you be interested? ❒ Yes ❒ No

I certify that I have read and understand the above information and that it is correct to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I understand it will be held in the strictest of confidence and only be used to improve communication between the doctor and myself. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners.

Signature of patient or parent if minor _____ Date _____