WELCOME TO OUR PRACTICE

ABOUT YOU

Today's Date: _____ Marital Status: Single Married Divorced Widowed Separated

Legal Name: _____ Name I prefer to be called :_____
Last First MI Mr. Mrs. Ms. Miss. Dr.

Date of Birth: ____/____/____ Age: _____ Social Security #: _____ Circle one: Male Female

Primary Address: _____
Street City State Zip

Secondary Address: _____
Street City State Zip

Are you a full time resident? Yes No If part time, when are you here during the year: _____

Home Phone #: (_____)_____ Cell #: (____) _____ Work #: (____) _____ Ext: _____
Email address:_____@_____
Whom may we thank for referring you?:_____Other family members seen by us: _____
Employer: _____ How long have you worked there: _____ Occupation: _____

Neighbor or Relative not living with you (Additional Contact)

His/ her Name: _____ Relation: _____ Home #: (____) _____ Work #: (____) _____
Address: _____
Street City State Zip

Person Responsible for Account if other than yourself

Name: _____ Relation: _____ Home #: (____) _____ Soc. Security #: _____
Employer: _____ Work #: (____) _____ Ext: _____ Drivers License #: _____
Billing Address: _____
Street City State Zip

SPOUSE INFORMATION

His/ Her Name: _____ Date of Birth: ____/____/_____ Soc. Security #: _____
Employer: _____ Work #: (____) _____ Ext: _____ Drivers License #:_____

PRIMARY DENTAL INSURANCE INFORMATION

Insurance Company Name: _____ Phone #: (_____) _____ Group #: _____
Insurance Company Address: _____
Street/PO Box City State Zip

Subscriber Info:
Name: _____ Social Security #: _____ Date of Birth: ____/____/____
Employer: _____ I.D. #: _____ Relation: _____

DENTAL HISTORY

Do your gums ever bleed? Y N Do you have mobility in your teeth? Y N
Are you happy with the way your smile looks? Y N Would you like whiter teeth? Y N
Do you now or have you ever experienced pain/discomfort in you jaw (TMJ/TMD)? Y N
Previous/Present Dentist: _____ Last Visit Date: _____
Reason for leaving your previous dentist:_____
What did you like most & least about any dentist you have seen? _____

MEDICAL HISTORY

Are you allergic to any of the following?

Y N	Aspirin	Y N	Erythromycin	Y N	Jewelry/Metals	Y N	Latex
Y N	Codeine	Y N	Dental Anesthetics	Y N	Penicillin	Y N	Sedatives
Y N	Tetracycline						

Additional drugs/ materials that may cause an allergic reaction: _____

Are you taking any of the following?

Y N	Birth Control Pills	Y N	Steroids/Cortisone	Y N	Nitroglycerin
Y N	Recreational Drugs	Y N	Tranquilizers	Y N	Thyroid Medicine
Y N	Insulin/ Diabetes Drugs	Y N	Blood Pressure Medication		

Y N Aspirin – Baby (81mg) or Adult (325 mg)? _____Is it Dr prescribed? Y N
Y N Blood Thinners - Name: _____
Y N Bone Density Medication - Do you take it by pill form or do you get it by I.V.?_____

Do you require antibiotics (AKA a pre-med) before dental treatment? Y N if Yes name: _____
Reason for taking Pre-Med:_____

If you have a list of medications please give to the front desk to copy or please list ALL prescription & over-the-counter drugs:_____
_____
_____

Do you or have you experienced the following?

Y N	Alzheimer	Y N	Cancer	Y N	Alcohol Abuse
Y N	Dementia	Y N	Anemia	Y N	Diabetes
Y N	Arthritis	Y N	Radiation Treatment	Y N	Difficulty Breathing
Y N	Drug Abuse	Y N	Fainting Spells	Y N	Hemophilia
Y N	Asthma	Y N	Hepatitis	Y N	High Blood Pressure
Y N	HIV+/AIDS	Y N	Kidney Problems	Y N	Liver Disease
Y N	Pacemaker	Y N	Psychiatric Problems	Y N	Blood Disorders
Y N	Seizures	Y N	Steroid Therapy	Y N	Stroke
Y N	Thyroid Disease	Y N	Tonsillitis	Y N	Tuberculosis (TB)
Y N	Venereal Disease	Y N	Artificial Valves	Y N	Abnormal Bleeding
Y N	Chemotherapy				

Y N Heart Condition Please explain: _____

Y N Artificial Bones/Joint When was surgery done?_____ Type of replacement: _____
Name of doctor that did surgery:_____ Dr phone #: (_____)_____

Are you pregnant? Unsure Yes No Week #: _____ Are you nursing? Yes No
If you are pregnant what is the name of your OBGYN?_____ Dr Phone# (_____)_____-_____

Please list any serious medical condition(s) that you have experienced: _____

Any recent surgeries? If so please list what and date: _____

Are you under the care of a physician? Y N Please explain:_____
Your current physical health is: Good Fair Poor Do you smoke or use tobacco in any form? Y N
Physician's Name: _____Phone #: (_____) _____Date of last visit: _____

PAYMENT IS DUE AT TIME OF SERVICE