Welcome

About You

Today's Date: _____

Name: _____
FIRST NAME LAST NAME

I prefer to be called: _____ ☐Male ☐Female

Birthdate:_____ Age:_____S.S.#:_____

Home Address: _____
STREET ADDRESS

_____ _____ _____
CITY STATE ZIP CODE

☐Single ☐Married ☐Divorced ☐Widowed ☐Partner

Home #: (_____)_____

Cell/other #: (_____)_____

Work #: (_____)_____

E-mail: _____

Employer: _____

Occupation: _____

Where & when are the best times to reach you?_____

Whom may we thank for referring you?_____

Other family members seen by us: _____

Present dentist: _____ How long? _____

Last visit date: _____

Spouse Information

Name: _____
FIRST NAME LAST NAME

Employer: _____

Work Number: (____)_____ Ext.:_____

SS #: _____

Birthdate: _____

Person Responsible for Account: _____
FIRST NAME LAST NAME

Billing Address: _____
STREET ADDRESS

_____ _____ _____
CITY STATE ZIP CODE

Relationship to Patient: _____

Employer: _____

Work Number: (____)_____ Ext.:_____

SS #: _____

Birthdate: _____

Medical History

How would you describe your health?
☐Excellent ☐Good ☐Fair ☐Poor

Do you Smoke? ☐☐
Packs/day___Years___

Physician's Name: _____
FIRST NAME LAST NAME

Phone Number:(_____)_____

Are you currently under the care of a physician? ☐No ☐Yes

Please explain_____

Please list any medication including aspirin and plavix_____

Has antibiotic premedication been advised before dental visits? ☐☐ Y N

Are you taking birth control pills? ☐No ☐Yes

Are you pregnant? ☐No ☐Yes

Have you ever had any of the following:

Y N		Y N	
☐☐	Heart Attack/Stroke	☐☐	Psychiatric Problems
Y N		Y N	
☐☐	Cancer/Chemotherapy	☐☐	Epilepsy/Seizures/Fainting
Y N		Y N	
☐☐	Heart Murmur	☐☐	Diabetes/Tuberculosis (TB)
Y N		Y N	
☐☐	Rheumatic Fever	☐☐	Drug/ Alcohol Abuse
Y N		Y N	
☐☐	HIV+ / AIDS	☐☐	Venereal Disease
Y N		Y N	
☐☐	Heart Surgery/Pacemaker	☐☐	Hemophilia/Abnormal Bleeds
Y N		Y N	
☐☐	Osteoporosis/ Meds for?	☐☐	Ulcers/Colitis
Y N		Y N	
☐☐	Mitral Valve Prolapse	☐☐	Congenital Heart Defect
Y N		Y N	
☐☐	Kidney Problems	☐☐	Anemia/ Radiation treatment
Y N		Y N	
☐☐	Artificial Bones/ Joints	☐☐	Asthma/ Arthritis
Y N		Y N	
☐☐	Sinus Problems/ Allergies	☐☐	Difficulty Breathing
Y N		Y N	
☐☐	High/Low Blood Pressure	☐☐	Hospitalized for Any Reason
Y N		Y N	
☐☐	Fever Blisters/ Shingles	☐☐	Blood Transfusion
Y N		Y N	
☐☐	Severe/ Freq. Headaches	☐☐	Emphysema/ Glaucoma
Y N			
☐☐	Thyroid		

Please list any serious medical conditions that you have had

Are you Allergic to any of the following drugs?

Y N	Y N	Y N
☐☐ Penicillin	☐☐ Tetracycline	☐☐ Latex
Y N	Y N	Y N
☐☐ Aspirin	☐☐ Dental Anesthetics	☐☐ Barbituates
Y N	Y N	
☐☐ Codeine	☐☐ Erythromycin	

Please list any other drug allergies: _____

DENTAL HISTORY

What is your primary concern about your mouth?

_____

Are you currently in pain? ☐No ☐Yes _____

Have you ever had a serious or difficult problem associated with any previous dental work? ☐No ☐Yes

_____

Do you now or have you ever experienced pain.discomfort in your jaw joint (TMJ)? ☐No ☐Yes

Does your teeth's appearance bother you? ☐No ☐Yes

Do your gums bleed? ☐No ☐Yes

Do you have a water pik? ☐No ☐Yes Use? ☐No ☐Yes

Use anything to clean between your teeth? ☐No ☐Yes

What? _____

When were your teeth last cleaned? _____

Have you ever been examined specifically for periodontal disease? ☐No ☐Yes When? _____ By Whom? _____

What was done? _____

Are you nervous before dental visits? ☐No ☐Yes

Do you frequently eat sweets, mints, or gum? ☐No ☐Yes

Are you bothered by persistent bad breath or a bad taste in your mouth? ☐No ☐Yes

How severe do you consider your gum problem?

☐ Minimal ☐ Generalized Moderate ☐ Generalized Severe

☐Localized to 1 or 2 areas

What special concerns or questions do you have about periodontal treatment?

What other information would help us serve you better?

DENTAL INSURANCE

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Phone #:(_____)_____

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

Insured's Name: _____ Relation:_____

Insured's Social Security #: _____

Insured's Birthday: _____

Insured's Employer: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co Phone #: (_____)_____

Social Security #: _____

Birthday: _____

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

PATIENT SIGNATURE

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 help in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

PLEASE SIGN AND DATE BELOW

_____ _____

Signature ***Date***

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help.

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.