WELCOME

1 Dental History

Reason for today's visit _____

_____

Former Dentist _____

Date of last dental visit _____

Date of last dental x-rays _____

Mark "Yes" or "No" to indicate if you presently have or previously had any of the following:

Bad breath	Yes ❑	No ❑
Bite your lips or cheeks regularly	Yes ❑	No ❑
Bleeding gums	Yes ❑	No ❑
Blisters on lips or mouth	Yes ❑	No ❑
Chew on one side of mouth	Yes ❑	No ❑
Dry mouth	Yes ❑	No ❑
Food collection between the teeth	Yes ❑	No ❑
Grinding teeth	Yes ❑	No ❑
Gums swollen or tender	Yes ❑	No ❑
Jaw pain or tiredness	Yes ❑	No ❑
Mouth breathing	Yes ❑	No ❑
Orthodontic treatment	Yes ❑	No ❑
Pain around ear	Yes ❑	No ❑
Periodontal (gum) treatment	Yes ❑	No ❑
Sensitivity to cold	Yes ❑	No ❑
Sensitivity to hot	Yes ❑	No ❑

Have you experienced:

Clicking or popping of the jaw?	Yes ❑	No ❑
Pain? (joint, ear, side of face)	Yes ❑	No ❑
Difficulty in opening or closing the mouth?	Yes ❑	No ❑

How often do you floss? _____

How often do you brush? _____

Do you require antibiotics before dental treatment?	Yes ❑	No ❑
Are you currently in pain?	Yes ❑	No ❑
Have you ever had a serious / difficult problem associated with any previous dental work?	Yes ❑	No ❑
Do you like your smile?	Yes ❑	No ❑
Do you feel nervous about having dental treatment?	Yes ❑	No ❑
Have you ever had a bad experience in a dental office?	Yes ❑	No ❑

If yes, please describe _____

_____

Is there anything else about having dental treatment that you would like us to know? _____

_____

_____

_____

2 Medical History

Your current physical health is:
❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? Yes ❑ No ❑
Please explain: _____

_____

Are you taking any prescription / over the counter drugs? Yes ❑ No ❑ Please list each one: _____

_____

_____

_____

_____

_____

_____

_____

Do you smoke or use tobacco in any other forms? Yes ❑ No ❑

For Women:

Are you taking birth control pills?	Yes ❑	No ❑
Are you pregnant?	Yes ❑	No ❑
Are you nursing?	Yes ❑	No ❑

Do you have or have you ever had any of the following diseases or medical problems?

Abnormal Bleeding	Yes ❑	No ❑
Alcohol / Drug Abuse	Yes ❑	No ❑
Alzheimer's Disease	Yes ❑	No ❑
Anemia	Yes ❑	No ❑
Arthritis	Yes ❑	No ❑
Artificial Bones / Joints / Valves	Yes ❑	No ❑
Asthma	Yes ❑	No ❑
Blood Transfusion	Yes ❑	No ❑
Bruise Easily	Yes ❑	No ❑
Cancer / Chemotherapy	Yes ❑	No ❑
Colitis	Yes ❑	No ❑
Diabetes	Yes ❑	No ❑
Difficulty Breathing	Yes ❑	No ❑
Emphysema	Yes ❑	No ❑
Epilepsy	Yes ❑	No ❑
Fainting Spells	Yes ❑	No ❑
Frequent Headaches	Yes ❑	No ❑
Glaucoma	Yes ❑	No ❑
Hay Fever	Yes ❑	No ❑
Heart Problems	Yes ❑	No ❑
Heart Murmur	Yes ❑	No ❑
Hemophilia	Yes ❑	No ❑
Hepatitis	Yes ❑	No ❑
Herpes / Fever Blisters	Yes ❑	No ❑
High Blood Pressure	Yes ❑	No ❑
HIV+ / AIDS	Yes ❑	No ❑
Hospitalized for Any Reason	Yes ❑	No ❑
Joint Replacement	Yes ❑	No ❑
Kidney Problems	Yes ❑	No ❑
Liver Disease	Yes ❑	No ❑
Low Blood Pressure	Yes ❑	No ❑
Mitral Valve Prolapse	Yes ❑	No ❑
Nervous/Anxious	Yes ❑	No ❑
Pacemaker	Yes ❑	No ❑
Psychiatric/Psychological Care	Yes ❑	No ❑
Radiation Treatment	Yes ❑	No ❑
Rheumatic / Scarlet Fever	Yes ❑	No ❑
Seizures	Yes ❑	No ❑
Sinus Problems	Yes ❑	No ❑
Stroke	Yes ❑	No ❑
Thyroid Problems	Yes ❑	No ❑
Tuberculosis (TB)	Yes ❑	No ❑
Tumors or Growths	Yes ❑	No ❑
Ulcers	Yes ❑	No ❑
Venereal Disease	Yes ❑	No ❑

Do you have or have you had any disease, condition, or problem not listed? Yes ❑ No ❑

Are you **allergic** to any of the following?

Aspirin	Yes ❑	No ❑
Codeine	Yes ❑	No ❑
Dental Anesthetics	Yes ❑	No ❑
Latex	Yes ❑	No ❑
Metals	Yes ❑	No ❑
Penicillin	Yes ❑	No ❑
Tetracycline	Yes ❑	No ❑

Please list any other drugs/materials that you are allergic to: _____

_____

_____

3

CERTIFICATION: I certify that the answers given are correct to the best of my knowledge.

Signature _____ Date _____

WELCOME

In order to ensure your maximum oral health and allow us to prescribe the proper medications, it is very important that we know all medical and dental information about you. Please check every box on the front and back of this form, even if the answer is "N/A" (not applicable). This information will be kept in the strictest confidence.

You also should know that changes in other parts of your body may affect the oral cavity and what dental treatment can be done, even if they seem unconnected. Cardiac (heart) problems, artificial joints and diabetes are just some examples.

Will you please inform the dentist or the staff at the beginning of each new office visit if your medical or dental conditions have changed since we last saw you? Yes ❑ No ❑. Thank you.

1 Patient Information

Date _____

Patient _____

Address _____

_____

City State Zip

I prefer to be called: ❑ Mr. ❑ Mrs. ❑ Miss ❑ Other _____

Birthdate _____ Gender: F ❑ M ❑ Age _____

❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient SS# _____ - _____ - _____

If patient is a minor, give parent's or guardian's name: _____

_____

Occupation _____

Employer _____

Spouse's Name _____

Spouse's Occupation _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 Phone Numbers

Home Phone _____

Work _____ Ext _____

Spouse's Work _____

Best time and place to reach you: _____

Family Physician's Name: _____

Physician's Phone: _____

Email Address: _____

_____

IN CASE OF EMERGENCY, CONTACT *(Specify someone who does not live in your household.)*

Name _____

Relationship _____

Home Phone _____

Work Phone _____

3 Dental Insurance

Who is responsible for this account? _____

SS# _____ Birthdate _____

Relationship to Patient: _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? Yes ❑ No ❑

Subscriber's Name: _____

Insurance Co.: _____

Group # _____

4

ASSIGNMENT AND RELEASE

I certify that I (or my dependent) have insurance coverage as indicated and assign directly to this office all insurance benefits otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature

_____ _____

Relationship to Minor (if applicable) *Date*