

Welcome To Our Practice!



Please fill out both sides of this form



Referred by: _____

Date: _____

Mr. Mrs. Ms Dr.

About You

Name: (First) _____ (Last) _____ Nickname: _____

Phone: Cell: _____ Home: _____ Work: _____ Other: _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security Number: _____ Date of Birth: _____

E-Mail: _____

Employer/Student: _____ Occupation/Major: _____

Spouse/Partner Information

Name: (First) _____ (Last) _____ Mr. Mrs. Ms Dr.

Phone: Cell: _____ Home: _____ Work: _____

Social Security Number: _____ Date of Birth: _____

Employer: _____

Primary Insurance Coverage

Insurance Co. Name: _____ Insurance Co. Phone#: _____

Group # (Plan, Local or Policy#): _____ Insured's Employer: _____

Insured's Date of Birth: _____ Insured's Social Security #: _____

Insured's Name: _____ Relationship to You: _____

Secondary Insurance

Insurance Co. Name: _____ Insurance Co. Phone#: _____

Group # (Plan, Local or Policy#): _____ Insured's Employer: _____

Insured's Date of Birth: _____ Insured's Social Security #: _____

Insured's Name: _____ Relationship to You: _____

Medical History

How long has it been since you visited a dentist? _____ Previous Dentist: _____

Do you have a any allergies we should be aware of? _____

Are you currently under the care of a physician? Please explain: _____

Please list all/any prescription medications/over the counter you are taking? _____

Do you smoke or use tobacco? _____ Are you pregnant or nursing? _____

Do/Have you taken Bisphosphonates (Gosamax, Actonel, Aredia, Didronel etc): _____

Physician's name/Phone/Emergency Contact: _____

Have you ever had any of the following?

- | | | | | | | | | |
|---|---|--------------------------------|---|---|---------------------|---|---|---------------------------|
| Y | N | Abnormal Bleeding | Y | N | Frequent Headaches | Y | N | Mitral Valve Prolapse |
| Y | N | Alcohol/Drug Abuse | Y | N | Glaucoma | Y | N | Pacemaker |
| Y | N | Anemia | Y | N | Hay Fever | Y | N | Psychiatric Problems |
| Y | N | Arthritis | Y | N | Heart Attack | Y | N | Radiation Treatment |
| Y | N | Artificial Bones/Joints/Valves | Y | N | Heart Murmur | Y | N | Rheumatic / Scarlet Fever |
| Y | N | Asthma | Y | N | Heart Surgery | Y | N | Seizures |
| Y | N | Blood Transfusion | Y | N | Hemophilia | Y | N | Shingles |
| Y | N | Cancer/Chemo | Y | N | Hepatitis | Y | N | Sickle Cell |
| Y | N | Colitis | Y | N | Herpes | Y | N | Sinus Problems |
| Y | N | Congenital Heart Defect | Y | N | High Blood Pressure | Y | N | Stroke |
| Y | N | Diabetes | Y | N | HIV+/AIDS | Y | N | Thyroid Problems |
| Y | N | Difficulty Breathing | Y | N | Hospitalized | Y | N | Tuberculosis |
| Y | N | Emphysema | Y | N | Kidney Problems | Y | N | Ulcers |
| Y | N | Epilepsy | Y | N | Liver Disease | Y | N | Venereal Disease |
| Y | N | Fainting Spells | Y | N | Low Blood Pressure | Y | N | Acid Reflux / Indigestion |

Why have you come to the dentist today? _____

Do you have a CPAP Sleep Apnea Machine? _____ How often do you use it? _____

Are you experiencing any pain near your teeth or jaw? _____

Do your gums bleed? _____ How often do you brush / Floss a day? _____

What type of brush do you use? Soft Medium Hard

Do you want whiter teeth? Yes No Do you want fresher breath? Yes No

On a scale of 1 to 10 (10=perfect) how would you rate your smile? 1 2 3 4 5 6 7 8 9 10

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. I authorize the dental team to perform any necessary dental services that I may need during the diagnosis and treatment with my informed consent.

Signature Date