Welcome

We would like to welcome you to our office. Our goal is to help you reach and maintain maximum dental health for a healthy white smile that lasts a lifetime.

1 About You

Today's Date: ____________________

Name: ____________________
Last First MI Mr. Mrs. Ms. Dr.

I prefer to be called: ____________ ☐ Male ☐ Female

Birthdate: ____/____/____ SS#: ____________

Home Address: ____________________
Apt/Condo#

____
City State Zip

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home Phone: ____________________

Work Phone: ____________ Ext. ______

Cell Phone: ____________________

Email Address: ____________________

Preferred Contact #: ____________________

Employer/Occupation: ____________________

Employer's Address: ____________________

Referred by: ____________________

2 Spouse Information

Their Name: ____________________

Employer: ____________________

Work #: ____________ Ext. ______

Birthdate: ____________ SS#: ____________

3 Dental Insurance

Primary Dental Insurance

Insurance Co. Name: ____________________

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

Insured's Name: ____________ Relation: ______

Insured's Birthdate:___/___/___ Insured's SS#: ______

Insured's Employer: ____________________

Secondary Dental Insurance

Insurance Co. Name: ____________________

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

Insured's Name: ____________ Relation: ______

Insured's Birthdate:___/___/___ Insured's SS#: ______

Insured's Employer: ____________________

In the event of an emergency, is there someone who lives near you that we should contact?

Their Name: ____________ Relation: ______

Work #: ____________ Home #: ____________

4 Medical History

Do you have a personal physician? ☐ Yes ☐ No

Their Name: ____________________

Their Phone: ____________________

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

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4 MEDICAL HISTORY CONT.

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

If yes, please explain: ______________________

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Are you taking any prescription/over-the-counter drugs?

☐ Yes ☐ No If yes, please list: ______________________

For women: Are you pregnant? ☐ No ☐ Yes, Wk. # ________

Do you need antibiotic premedication before dental treatment?
☐ Yes ☐ No

Have you had any serious medical problems in the last 5 years?

☐ Yes ☐ No If yes, please explain: ______________________

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

Y	N	Heart Attack/Stroke	Y	N	Cancer/Chemotherapy
Y	N	Rheumatic Fever	Y	N	HIV + AIDS
Y	N	Heart Surgery/Pacemaker	Y	N	Shingles
Y	N	Chronic Hepatitis	Y	N	Kidney Problems
Y	N	Anemia	Y	N	Sinus Problems
Y	N	High/Low Blood Pressure	Y	N	Fever Blisters
Y	N	Severe Headaches	Y	N	Psychiatric Problems
Y	N	Epilepsy/Seizures/Fainting	Y	N	Diabetes
Y	N	Drug/Alcohol Abuse	Y	N	Tuberculosis (TB)
Y	N	Hemophilia/Abnormal Bleeding	Y	N	Sickle Cell Disease

Please list any other serious medical conditions that you have

had: ______________________

Are you allergic to any of the following drugs?

Y	N	Penicillin	Y	N	Aspirin
Y	N	Erythromycin	Y	N	Tetracycline
Y	N	Dental Anesthetics	Y	N	Codeine
Y	N	Sulfur	Y	N	Latex

Are you allergic to any other drugs? ☐ Yes ☐ No

If yes, please explain: ______________________

Have you ever had a skin reaction to jewelry? ☐ Yes ☐ No

If yes, please specify: ______________________

5 DENTAL HISTORY

Why have you come to the dentist today? ______________________

Is there anything you want to change about your smile? ________

Are you interested in whiter teeth? ☐ Yes ☐ No

Have you ever used Botox or Facial Derma Fillers? ☐ 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 now have or you ever experienced pain / discomfort in your jaw joint (TM / TMD)? ☐ Yes ☐ No

Do you snore or do others complain of your snoring? ☐ Yes ☐ No

6 PREVENTIVE CARE

Don't Wait Until It Hurts

Periodontal disease is painless. It affects 87% of the population, and often victims are unaware. There are warnings signs, and the American Dental Association and our staff want you to be aware.

1. Do your gums bleed when you brush your teeth or toothpick between them **Y N**
2. Are your gums red, swollen, or tender? **Y N**
3. Are your gums pulling away from your teeth? **Y N**
4. Do you see pus between your teeth and your gums when gums are pressed? **Y N**
5. Are your permanent teeth loose or separating? **Y N**
6. Is there any change in the way your teeth hit together when you bite? **Y N**
7. Is there any change in the fit of your partial dentures? **Y N**
8. Do you have bad breath? **Y N**
9. Do you have any dark stains in the grooves of your teeth? **Y N**

If the answer is yes to any of these questions, you owe it to yourself to bring it to the attention of your dentist or hygienist. Act now and keep your teeth for a lifetime.

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

____

Signature Date

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