



# Welcome

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The benefits of a healthy, happy smile are immeasurable! Our main goal is to help you achieve and maintain your maximum oral health and a smile you are proud to show off. [Please fill out this form as completely as possible.](#) We want to make sure we are well informed about your medical history, current medications, and any other factor that might affect your dental health and treatment. The better we communicate, the better we are able to take great care of you.

## ABOUT YOU

Today's Date: \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

Name (First, Middle, Last): \_\_\_\_\_

I prefer to be addressed as: \_\_\_\_\_ Circle One: **Male** **Female**

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ SS#: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Circle One: **Single** **Married** **Widowed** **Divorced** **Separated** **Partnered**

Spouse's Name: \_\_\_\_\_

Spouse's Birthdate: \_\_\_\_\_ SS#: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

When and where are the best times to reach you? \_\_\_\_\_

Other Family Members Seen by Us: \_\_\_\_\_

## EMERGENCY CONTACT (Please specify someone who does not live in your household).

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

## MEDICAL HISTORY

Do you have a physician? **Yes** **No** Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of Last Physical: \_\_\_\_\_ Current Physical Health: **Excellent** **Good** **Fair** **Poor** **Very Poor**

Are you currently under the care/supervision of a physician? **Yes** **No** Please Explain: \_\_\_\_\_

Are you currently taking any prescription medications? **Yes** **No** **Please list medications with correlating diagnosis:** \_\_\_\_\_

**For Women:** Are you currently taking any oral contraceptives (birth control pills)? **Yes** **No** Are you pregnant? **Yes** **No** Are you nursing? **Yes** **No**

Do you or have you ever used tobacco in any form? **Yes** **No** If yes, how much? \_\_\_\_\_ For how long? \_\_\_\_\_

**ALLERGIES** - Circle any and all of the following to which you are allergic:

**Aspirin • Barbiturates/Sleeping Pills • Codeine • Dental Anesthetics • Erythromycin • Ibuprofen/Motrin • Jewelry/Metals • Latex • Percocet • Penicillin • Tetracycline • Vicodin**

Please list any other medications and/or materials to which you think you are allergic: \_\_\_\_\_

## DENTAL INSURANCE

Person Responsible for Account (If other than yourself): \_\_\_\_\_

Do you have dental insurance coverage? **Yes** **No**

Dental Insurance Co. Name: \_\_\_\_\_

Dental Insurance Co. Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Dental Insurance Co. Phone: \_\_\_\_\_

Group # (Plan, Local, or Policy#): \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Insured's Birthdate: \_\_\_\_\_ SS#: \_\_\_\_\_

Insured's Home Phone: \_\_\_\_\_ Alt. Phone: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

## ACKNOWLEDGEMENTS & SIGNATURES

I acknowledge that the information I give in this form is correct to the best of my knowledge, and I understand that this information will be held in the strictest confidence. I also understand that it is my responsibility to inform this office of any changes in my insurance or medical status.

I understand that I am required to pay for any dental services provided. In the situation where my insurance plan does not pay for a portion or all of a procedure, I acknowledge that I am responsible to pay in full for that procedure.

I, the undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and assign benefit payment directly to the doctor (even if otherwise payable to me) for service rendered. I understand that a finance charge may be applied for any balance that goes beyond 90 days.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

### MEDICAL CONDITIONS

Have you ever had any of the following medical conditions? **Circle "Yes" or "No"**

Abnormal Bleeding	<b>Yes</b>	<b>No</b>	Frequent Headaches	<b>Yes</b>	<b>No</b>	Mitral Valve Prolapse	<b>Yes</b>	<b>No</b>
Alcohol or Drug Abuse	<b>Yes</b>	<b>No</b>	Glaucoma	<b>Yes</b>	<b>No</b>	Pacemaker	<b>Yes</b>	<b>No</b>
Anemia	<b>Yes</b>	<b>No</b>	Hay Fever	<b>Yes</b>	<b>No</b>	Psychiatric Problems	<b>Yes</b>	<b>No</b>
Arthritis	<b>Yes</b>	<b>No</b>	Heart Attack	<b>Yes</b>	<b>No</b>	Radiation Treatment	<b>Yes</b>	<b>No</b>
Artificial Bones/Joints/Valves	<b>Yes</b>	<b>No</b>	Heart Murmur	<b>Yes</b>	<b>No</b>	Rheumatic/Scarlet Fever	<b>Yes</b>	<b>No</b>
Asthma	<b>Yes</b>	<b>No</b>	Heart Surgery	<b>Yes</b>	<b>No</b>	Seizures	<b>Yes</b>	<b>No</b>
Blood Transfusion	<b>Yes</b>	<b>No</b>	Hemophilia	<b>Yes</b>	<b>No</b>	Shingles	<b>Yes</b>	<b>No</b>
Cancer/Chemotherapy	<b>Yes</b>	<b>No</b>	Hepatitis	<b>Yes</b>	<b>No</b>	Sickle Cell Disease/Traits	<b>Yes</b>	<b>No</b>
Colitis	<b>Yes</b>	<b>No</b>	Herpes/Fever Blisters	<b>Yes</b>	<b>No</b>	Sinus Problems	<b>Yes</b>	<b>No</b>
Congenital Heart Disease	<b>Yes</b>	<b>No</b>	High Blood Pressure	<b>Yes</b>	<b>No</b>	Sleep Apnea	<b>Yes</b>	<b>No</b>
Diabetes	<b>Yes</b>	<b>No</b>	HIV or AIDS	<b>Yes</b>	<b>No</b>	Stroke	<b>Yes</b>	<b>No</b>
Difficulty Breathing	<b>Yes</b>	<b>No</b>	Hospitalized for Any Reason	<b>Yes</b>	<b>No (If yes, please explain below.)</b>			
Emphysema	<b>Yes</b>	<b>No</b>	Kidney Problems	<b>Yes</b>	<b>No</b>	Thyroid Problems	<b>Yes</b>	<b>No</b>
Epilepsy	<b>Yes</b>	<b>No</b>	Liver Disease	<b>Yes</b>	<b>No</b>	Tuberculosis	<b>Yes</b>	<b>No</b>
Fainting Spells	<b>Yes</b>	<b>No</b>	Low Blood Pressure	<b>Yes</b>	<b>No</b>	Venereal Disease	<b>Yes</b>	<b>No</b>

Please explain any serious medical conditions you have ever had:

### DENTAL HISTORY

Why have you come to our office today? \_\_\_\_\_ Are you in pain? **Yes No** If yes, for how long? \_\_\_\_\_

Previous Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_ Last Visit Date: \_\_\_\_\_

What was done? \_\_\_\_\_ Date of Last Cleaning: \_\_\_\_\_ Date of Last Dental X-rays: \_\_\_\_\_

Have you ever been told that you require antibiotics before dental treatment? **Yes No**

Do you have or have you ever had any of the following conditions, ailments, or treatments? **Circle "Yes" or "No"**

Bad Breath	<b>Yes</b>	<b>No</b>	Food Collection Between Teeth	<b>Yes</b>	<b>No</b>	Pain Around Ear	<b>Yes</b>	<b>No</b>
Bleeding Gums	<b>Yes</b>	<b>No</b>	Foreign Objects in Mouth	<b>Yes</b>	<b>No</b>	Pain When Brushing	<b>Yes</b>	<b>No</b>
Blisters on Lips or in Mouth	<b>Yes</b>	<b>No</b>	Grinding Teeth	<b>Yes</b>	<b>No</b>	Periodontal Treatment	<b>Yes</b>	<b>No</b>
Broken Fillings	<b>Yes</b>	<b>No</b>	Gums Swollen or Tender	<b>Yes</b>	<b>No</b>	Sensitivity to Cold	<b>Yes</b>	<b>No</b>
Burning Sensation on Tongue	<b>Yes</b>	<b>No</b>	Jaw Pain	<b>Yes</b>	<b>No</b>	Sensitivity to Heat	<b>Yes</b>	<b>No</b>
Chew on Only One Side	<b>Yes</b>	<b>No</b>	Jaw Fatigue	<b>Yes</b>	<b>No</b>	Sensitivity to Sweets	<b>Yes</b>	<b>No</b>
Clenching of Teeth	<b>Yes</b>	<b>No</b>	Lip or Cheek Biting	<b>Yes</b>	<b>No</b>	Sensitivity When Chewing	<b>Yes</b>	<b>No</b>
Clicking or Popping of Jaw	<b>Yes</b>	<b>No</b>	Loose Teeth	<b>Yes</b>	<b>No</b>	Snoring	<b>Yes</b>	<b>No</b>
Dry Mouth	<b>Yes</b>	<b>No</b>	Orthodontic Treatment	<b>Yes</b>	<b>No</b>	Sores or Growths in Mouth	<b>Yes</b>	<b>No</b>

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

Do you ever experience pain in your jaw joint (TMJ/TMD)? **Yes No**

How would you classify your current dental health? **Excellent Good Fair Poor Very Poor**

On a scale of 1-10, how would you rate your smile (10 being the best)? \_\_\_\_\_ Would you like whiter teeth? **Yes No**

Would you like straighter teeth? **Yes No** What else about your smile would you like to change? \_\_\_\_\_

Do you feel anxiety about dental treatment? **Yes No** On a scale of 1-10, how would you rate your anxiety (10 being the most anxious)? \_\_\_\_\_

On average, how many times a day do you brush? \_\_\_\_\_ How many times a week do you floss? \_\_\_\_\_

What type of bristles does your toothbrush have? **Soft Medium Hard**