

# Welcome to our office

## 1 Personal Information

Patient Name: \_\_\_\_\_

I prefer to be called: \_\_\_\_\_

Birth date: \_\_\_ / \_\_\_ / \_\_\_ SS#: \_\_\_\_\_

Minor  Single  Married  Divorced

Male  Female

Home Address:

Street: \_\_\_\_\_

City/Zip: \_\_\_\_\_

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

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

Pager/Cell Phone: \_\_\_\_\_

E-mail address: \_\_\_\_\_

May we contact you at work? Y N

When and where is the best time to reach you? \_\_\_\_\_

\_\_\_\_\_

Driver's License #: \_\_\_\_\_

Who is responsible for this account? \_\_\_\_\_

\_\_\_\_\_

Do you have (please circle all that apply):

VISA MC Discover Checking Account

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

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

Name of Spouse: \_\_\_\_\_

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

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

Spouse's Work Phone: \_\_\_\_\_

May he/she be contacted at work? Y N

Parents (if patient is a child): \_\_\_\_\_

Who may we thank for referring you to us? \_\_\_\_\_

## 2 Insurance Information

### PRIMARY INSURANCE

Male

Female

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

Birth date: \_\_\_\_\_ / \_\_\_ / \_\_\_ SS#: \_\_\_\_\_

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

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

\_\_\_\_\_

Ins. Co. Name: \_\_\_\_\_

Ins. Co. Address: \_\_\_\_\_

\_\_\_\_\_

Ins. Co. Phone: \_\_\_\_\_

Policy#: \_\_\_\_\_

Group#: \_\_\_\_\_

### SECONDARY INSURANCE

Male

Female

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

Birth date: \_\_\_\_\_ / \_\_\_ / \_\_\_ SS# \_\_\_\_\_

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

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

\_\_\_\_\_

Ins. Co. Name: \_\_\_\_\_

Ins. Co. Address: \_\_\_\_\_

\_\_\_\_\_

Ins. Co. Phone: \_\_\_\_\_

Policy#: \_\_\_\_\_

Group #: \_\_\_\_\_

### 3 Medical History

Do you have a personal physician? Y N

Their Name \_\_\_\_\_

Their phone: \_\_\_\_\_

The approximate date of your last doctors visit: \_\_\_\_\_

Your current physical health is: Good Fair Poor

Are you currently under the care of any physician? Y N

If yes, please explain: \_\_\_\_\_

Do you smoke or use tobacco in any form? Y N

Are you presently taking any drugs prescribed by a physician or dentist? Y N

If yes, please list: \_\_\_\_\_

**Do you need to be premedicated before dental treatment? Y N**

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

If yes, please explain: \_\_\_\_\_

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

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

**Do you have any known sensitivity to metals? Y N**

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

- Y N Penicillin
- Y N Erythromycin
- Y N Dental Anesthetics
- Y N Aspirin
- Y N Tetracycline
- Y N Codeine

Are you allergic to any other drugs? Y N

If yes please list \_\_\_\_\_

### 4 Dental History

Why have you come to the dentist today? \_\_\_\_\_

\_\_\_\_\_

Approximate date of your last dentist visit? \_\_\_\_\_

Do your gums ever bleed? Y N

Have you had any periodontal (gum) treatment? Y N

Has any member of your family been diaqnosed with gum disease? Y N

Do you like your smile? Y N

Would you like your teeth to be whiter Y N

Have you ever experienced pain in your TMJ (Jaw Joint)? Y N

Do you ever experience popping or clicking noises in your jaw when you chew or open/close your mouth? Y N

Are you apprehensive about dental treatment? Y N

What is most important to you concerning your teeth? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Would you like to prevent dentures? Y N

Please tell us anything we can do to make your dental visits more comfortable for you. \_\_\_\_\_

\_\_\_\_\_

Please list an Emergency Contact Person who does not live with you.

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Relationship to you? \_\_\_\_\_

**The above information is correct and I will inform the office of any changes. I understand that I am responsible for all costs of treatment and assign insurance benefits to the doctor. I understand that any outstanding balance is subject to finance charges if over 60 days past due. I have reviewed the office's privacy policy to protect health information and I give permission to be contacted concerning upcoming appointments or financial arrangements.**

**X** \_\_\_\_\_

Signature

Date

### OFFICE USE ONLY

DATE/INITIAL

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### MEDICAL HISTORY UPDATE

DATE/INITIAL

\_\_\_\_\_  
\_\_\_\_\_  
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DATE/INITIAL

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