

# Welcome to our office

## Personal Information

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

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

Reason for today's visit: \_\_\_\_\_

Last dental exam: \_\_\_\_\_

Birth Date: \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_\_\_

Minor Single Married Divorced

Parents Names, if Minor: Father: \_\_\_\_\_

Mother: \_\_\_\_\_

Male  Female

Home Address:

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

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

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

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

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

Email address: \_\_\_\_\_

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

The account will be paid by:

Cash Check Credit Card CareCredit

Do you have any known sensitivity to metals? Y N

Do you have any known sensitivity to LATEX? Y N

Are you allergic to any of the following?

(please circle)

Penicillin

Aspirin

Erythromycin

Dental Anesthetics (Novacaine)

Other drug allergies (please list): \_\_\_\_\_  
\_\_\_\_\_

## Medical History

Do you have a personal physician? Y N

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

Their Phone: \_\_\_\_\_

Date of your last visit: \_\_\_\_\_

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

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

Are you presently taking any prescribed drugs? Y N

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

Do you need to be pre-medicated before dental treatment? Y N

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

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

(please circle)

Artificial Heart Valves

Psychiatric Problems

Artificial Joints

Drug/Alcohol Abuse

Endocarditis

Abnormal Bleeding

Diabetes

Osteoporosis

Heart Attack, Stroke, Angina

Severe Headaches

High/Low Blood Pressure

HIV+/AIDS

Heart Surgery/Pacemaker

Sinus Problems

Epilepsy/Seizures/Fainting

Anemia

Heart Murmur/Rheumatic Fever

Sickle Cell Disease

Chronic Hepatitis

Tuberculosis

Dental History

Are you apprehensive about dental treatment?

	Y	N
Do you experience bad breath?	Y	N
Do your gums ever bleed?	Y	N
Has any family member been diagnosed with gum disease?	Y	N
Have you ever experienced pain in your TMJ (Jaw Joint)?	Y	N
Do you grind your teeth?	Y	N
What is most important to you concerning your teeth?	_____	
	_____	
	_____	

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

Please list an Emergency Contact Person:

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

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

Insurance Information

**Primary Insurance**

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

Birth Date: \_\_\_/\_\_\_/\_\_\_ SS#: \_\_\_\_\_

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

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

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

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

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

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

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

**Secondary Insurance**

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

Birth Date: \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_\_\_

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

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

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

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

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

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

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

The above information is correct and I will inform the office of any changes. I understand I am responsible for all costs of treatment and assign insurance benefits to the doctor.

X \_\_\_\_\_  
Signature Date

OFFICE USE ONLY

MEDICAL HISTORY UPDATE

DATE/INITIAL

DATE/INITIAL

DATE/INITIAL

DATE/INITIAL

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

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

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

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