*Welcome....*
*to our practice!*

Name:________________________________ I prefer to be called:_______________ D.O.B:__________________

Age:______________ Male [ ] Female [ ] SS#:____________________ Email:________________________

Home address:______________________________________________________________________

Single [ ] Married [ ] Other [ ] Home#:( )____________________Cell#:( )_____________________

Employer:____________________________________________Occupation:________________________________

Employer Address:_______________________________________________ Work#:( )____________________

How long there?:___________________ Where/Best time to reach you?:_______________________________

**Whom may we thank for referring you?**_________________Other Family seen by us?______________________

Previous Dentist?:____________________________________Last Dental Exam?:____________________________

Spouse Information: Spouse Name:________________________________ Spouse D.O.B:____________________

Spouse Employer:_______________________________________

Emergency Contact- Name/Relationship:__________________________________ Phone#: ( )______________

Who is responsible for this account:__________________________________________________________

**Primary Insurance:**

Dental Insurance Name:___________________________ Insurance Address:_______________________________

Ins Company Phone#:( )__________________ID#:__________________________Group#:________________

Whom carries this Dental Plan?___________________________

If not listed above: Insured's Name:_________________________________________ D.O.B:__________________

**Payment is due in full at the time of visit unless prior arrangements have been approved.** This office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered to my insurance company.

Signature: ____________________________________________________________ Date:___________________

**MEDICAL HISTORY:** (Please Circle Answers)

Why have you come to the dentist today?

________________________________________________________________________________

Do you have a personal physician? **Yes** **No** Physicians Name:________________________________

Are you currently under the care of a physician? **Yes** **No**

Your current Physical Health is? **Good** **Fair** **Poor**

Do you smoke or use tobacco? **Yes** **No**

Have you had any metal rods, pins or implants? **Yes** **No** Explain:______________________________

Have you been hospitalized in the last 5 years? **Yes** **No** Explain:______________________________

Have you ever taken Fosamax, or any other bisphosphonate (typically prescribed for osteoporosis)? **Yes** **No**

Do you or your family have a history of cancer? **Yes** **No** Explain:______________________________

Do you or your family have a history of heart disease? **Yes** **No** Explain:__________________________

**FOR WOMEN:** Are you using a prescribed method of birth control? **Yes** **No**

Are you pregnant? **Yes** **No** Weeks#:____________________ Are you nursing? **Yes** **No**

**DENTAL HISTORY:** Are you currently in pain? **Yes** **No**

Do you require antibiotics before dental treatment? **Yes** **No**

Your current dental health is Good [ ] Fair [ ] Poor [ ]

Do you floss daily? **Yes** **No**

Have you ever had gum treatment? **Yes** **No**

Have you ever had periodontal disease? **Yes** **No**

Do you now or have you ever experienced pain/ discomfort in your jaw joint (TMJ/TMD)? **Yes** **No**

Are your teeth sensitive to heat, cold or anything else? Please List ________________________________

Do you have loose teeth? **Yes** **No**

Do you still have wisdom teeth? **Yes** **No**

Would you like fresher breath? **Yes** **No**

Would you like a whiter smile? **Yes** **No**

Are you happy with the way your smile looks? **Yes** **No** If not what would you change?________________

**What Pharmacy do you use?**:__________________________________________________

**Pharmacy Phone #:**______________________ **Address**:______________________________

**Have you ever had any of the following? Please check □**

| | | |
|---|---|---|
| □ Abnormal bleeding | □ Fainting | □ Nervous Disorders |
| □ AIDS/HIV | □ Frequent headaches | □ Pacemaker |
| □ ADD/ADHD | □ Glaucoma | □ Parkinson's |
| □ Anemia | □ Hay Fever | □ Psychiatric Treatment |
| □ Arthritis | □ Head Injury | □ Radiation Treatment |
| □ Artificial joints | □ Heart Attack | □ Respiratory Problems |
| □ Asthma | □ Heart Disease | □ Rheumatic Fever |
| □ Blood disease | □ Heart Murmur | □ Scarlet Fever |
| □ Blood transfusion | □ Heart Surgery | □ Seizures |
| □ Cancer | □ Heart Transplant | □ Shingles |
| □ Chemotherapy | □ Hepatitis | □ Sinus Problems |
| □ Cold Sores | □ Herpes | □ Stomach Problems |
| □ Colitis | □ High Blood Pressure | □ Stroke |
| □ Congenital heart defect | □ Kidney Disease | □ Stints/Shunts |
| □ Dementia | □ Kidney Problems | □ Substance Abuse |
| □ Diabetes | □ Kidney Transplant | □ TB |
| □ Dialysis | □ Liver disease | □ Thyroid Problems |
| □ Difficulty breathing | □ Liver transplant | □ Tumors |
| □ Dizziness | □ Low Blood Pressure | □ Ulcers |
| □ Emphysema | □ Lupus | □ Venereal Disease |
| □ Epilepsy | □ Mitral Valve Prolapse | |

**Are you allergic to any of the following? Please check □**

| | | |
|---|---|---|
| □ Codeine | □ Iodine | □ Sulfa |
| □ Dental Anesthetics | □ Latex | □ Tetracycline |
| □ Erythromycin | □ Penicillin | □ Other:___________________ |

**Are you taking any prescriptions or over the counter drugs? YES NO**

Please List:______________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

**SLEEP HEALTH:** Do you feel tired throughout the day? **YES** **NO** Explain: ____________________________

Do you wish you slept better and had more energy? **YES** **NO** Explain: ____________________________

Have you ever been told you occasionally snore? **YES** **NO** Explain: ____________________________

Have you or a loved one been prescribed a CPAP? **YES** **NO** Explain: ____________________________

**I understand that the information I've 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 that I may need during diagnosis and treatment, with my informed consent.

Signature__________________________________________________ Date:______________________________