

# WELCOME

## ABOUT YOU

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_  
FIRST NAME LAST NAME

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

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ S.S.#: \_\_\_\_\_

Home Address: \_\_\_\_\_  
STREET ADDRESS

CITY STATE ZIP CODE

Single  Married  Divorced  Widowed  Partner

Home #: (\_\_\_\_) \_\_\_\_\_

Cell/other #: (\_\_\_\_) \_\_\_\_\_

Work #: (\_\_\_\_) \_\_\_\_\_

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

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

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

Where & when are the best times to reach you? \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Other family members seen by us: \_\_\_\_\_

Present dentist: \_\_\_\_\_ How long? \_\_\_\_\_

Last visit date: \_\_\_\_\_

## SPOUSE INFORMATION

Name: \_\_\_\_\_  
FIRST NAME LAST NAME

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

Work Number: (\_\_\_\_) \_\_\_\_\_ Ext.: \_\_\_\_\_

SS #: \_\_\_\_\_

Birthdate: \_\_\_\_\_

**Person Responsible for Account:** \_\_\_\_\_  
FIRST NAME LAST NAME

Billing Address: \_\_\_\_\_  
STREET ADDRESS

CITY STATE ZIP CODE

Relationship to Patient: \_\_\_\_\_

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

Work Number: (\_\_\_\_) \_\_\_\_\_ Ext.: \_\_\_\_\_

SS #: \_\_\_\_\_

Birthdate: \_\_\_\_\_

## MEDICAL HISTORY

How would you describe your health?  Excellent  Good  Fair  Poor

Do you Smoke?    
Packs/day \_\_\_ Years \_\_\_

Physician's Name: \_\_\_\_\_  
FIRST NAME LAST NAME

Phone Number: (\_\_\_\_) \_\_\_\_\_

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

Please explain \_\_\_\_\_

Please list any medication including aspirin and plavix  
\_\_\_\_\_

Has antibiotic premedication been advised before dental visits?

Are you taking birth control pills?  No  Yes

Are you pregnant?  No  Yes

**Have you ever had any of the following:**

<input type="checkbox"/> Heart Attack/Stroke	<input type="checkbox"/> Psychiatric Problems
<input type="checkbox"/> Cancer/Chemotherapy	<input type="checkbox"/> Epilepsy/Seizures/Fainting
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Diabetes/Tuberculosis (TB)
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Drug/ Alcohol Abuse
<input type="checkbox"/> HIV+ / AIDS	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Heart Surgery/Pacemaker	<input type="checkbox"/> Hemophilia/Abnormal Bleeds
<input type="checkbox"/> Osteoporosis/ Meds for?	<input type="checkbox"/> Ulcers/Colitis
<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Congenital Heart Defect
<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Anemia/ Radiation treatment
<input type="checkbox"/> Artificial Bones/ Joints	<input type="checkbox"/> Asthma/ Arthritis
<input type="checkbox"/> Sinus Problems/ Allergies	<input type="checkbox"/> Difficulty Breathing
<input type="checkbox"/> High/Low Blood Pressure	<input type="checkbox"/> Hospitalized for Any Reason
<input type="checkbox"/> Fever Blisters/ Shingles	<input type="checkbox"/> Blood Transfusion
<input type="checkbox"/> Severe/ Freq. Headaches	<input type="checkbox"/> Emphysema/ Glaucoma
<input type="checkbox"/> Thyroid	

Please list any serious medical conditions that you have had  
\_\_\_\_\_

**ARE YOU ALLERGIC TO ANY OF THE FOLLOWING DRUGS?**

<input type="checkbox"/> Penicillin	<input type="checkbox"/> Tetracycline	<input type="checkbox"/> Latex
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Dental Anesthetics	<input type="checkbox"/> Barbituates
<input type="checkbox"/> Codeine	<input type="checkbox"/> Erythromycin	

Please list any other drug allergies: \_\_\_\_\_

## DENTAL HISTORY

What is your primary concern about your mouth?  
\_\_\_\_\_

Are you currently in pain? No Yes \_\_\_\_\_

Have you ever had a serious or difficult problem associated with any previous dental work? No Yes  
\_\_\_\_\_

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

Does your teeth's appearance bother you? No Yes

Do your gums bleed? No Yes

Do you have a water pik? No Yes Use? No Yes

Use anything to clean between your teeth? No Yes

What? \_\_\_\_\_

When were your teeth last cleaned? \_\_\_\_\_

Have you ever been examined specifically for periodontal disease? No Yes When? \_\_\_\_\_ By Whom? \_\_\_\_\_

What was done? \_\_\_\_\_

Are you nervous before dental visits? No Yes

Do you frequently eat sweets, mints, or gum? No Yes

Are you bothered by persistent bad breath or a bad taste in your mouth? No Yes

How severe do you consider your gum problem?

Minimal  Generalized Moderate  Generalized Severe

Localized to 1 or 2 areas

What special concerns or questions do you have about periodontal treatment?  
\_\_\_\_\_

What other information would help us serve you better?  
\_\_\_\_\_

## DENTAL INSURANCE

### Primary Dental Insurance

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

Insurance Co. Phone #: C D \_\_\_\_\_

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

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

Insured's Social Security #: \_\_\_\_\_

Insured's Birthday: \_\_\_\_\_

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

### Secondary Dental Insurance

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

Insurance Co Phone #: C D \_\_\_\_\_

Social Security #: \_\_\_\_\_

Birthday: \_\_\_\_\_

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

## PATIENT SIGNATURE

*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 help in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.*

**PLEASE SIGN AND DATE BELOW**

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

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

*Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help.*

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