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WELCOME! The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health.

Please fill out this form completely. The better we communicate, the better we can care for you.

1 PATIENT INFORMATION

Today's Date ________ Person filling out if other than patient ________

Name: ________ (Last, First, MI, Mr. Mrs. Ms Dr)

I prefer to be called: ________ ❑ Male ❑ Female

Birthdate __/__/__ Age: ______ SS#: ________

Home Address: ________ Apt # ____

City ____ State ____ Zip ____

Mailing Address: ________

City ____ State ____ Zip ____

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Home #: (___) ________ Cell #: (___) ________

Work #: (___) ________ Ext.: ________

Employer: ________

Employer's Address: ________

Occupation: ________ How long there? ________

When & where are the best times to reach you? ________

How did you hear about our office? ________

Other family members seen by us: ________

Previous/Present Dentist: ________

Last visit date? ________ Were X-rays taken? ________

2 SPOUSE INFORMATION

Name: ________ SS#: ________

Employer ________

Work #: (___) ________ Ext: ________

DOB: __/__/__ Cell #: (___) ________

3 INSURANCE

Primary Insurance

Dental Coverage? ❑ Yes ❑ No

Insurance Co. Name: ________

Address: ________

City ____ State ____ Zip ____

Phone #: (___) ________ Group #: ________

Insured's Name: ________ Relation: ________

Insured's DOB: __/__/__ SS#: ________

Employer: ________

Employer's Phone #: (___) ________

Secondary Insurance

Dental Coverage? ❑ Yes ❑ No

Insurance Co. Name: ________

Address: ________

City ____ State ____ Zip ____

Phone #: (___) ________ Group #: ________

Insured's Name: ________ Relation: ________

Insured's DOB: __/__/__ SS#: ________

Employer: ________

Employer's Phone #: (___) ________

4 EMERGENCY INFORMATION

Whom may we contact in case of emergency? ________

____

Do you have a personal Physician? ________

Do you see any Medical Specialists? ________

If so, list name and phone #: ________

____

____

Nearest relative not living with you: ________

Address: ________

City ____ State ____ Zip ____

Phone #: (___) ________ Relation: ________

Nearest friend not living with you: ________

Address: ________ Phone #: (___) ________

FORM 009501 R/06/15 ITEM 6101

5 MEDICAL HISTORY

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ Yes ❑ No
Please explain: ______

Do you smoke or use tobacco in any other form? ❑ Yes ❑ No

Have you had any metal rods, pins or implants? ❑ Yes ❑ No

Are you taking any prescription / over-the-counter drugs? ❑ Yes ❑ No
Please list each one: ______

Have you ever taken Phen-Fen? (Also known as Redux or Pondimin) ❑ Yes ❑ No
If so when? ______

Are you currently taking any medication that causes dry mouth? ❑ Yes ❑ No

For Women: Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No Week #____ nursing? ❑ Yes ❑ No

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

Y	N	Abnormal Bleeding	Y	N	Hepatitis
Y	N	Alcohol / Drug Abuse	Y	N	Herpes / Fever Blisters
Y	N	Anemia	Y	N	High Blood Pressure
Y	N	Arthritis	Y	N	HIV+ / AIDS
Y	N	Artificial Bones / Joints / Valves	Y	N	Hospitalized for Any Reason
Y	N	Asthma	Y	N	Kidney Problems
Y	N	Blood Transfusion	Y	N	Liver Disease
Y	N	Cancer / Chemotherapy	Y	N	Low Blood Pressure
Y	N	Colitis	Y	N	Mitral Valve Prolapse
Y	N	Congenital Heart Defect	Y	N	Pacemaker
Y	N	Diabetes	Y	N	Psychiatric Problems
Y	N	Difficulty Breathing	Y	N	Radiation Treatment
Y	N	Emphysema	Y	N	Rheumatic / Scarlet Fever
Y	N	Epilepsy	Y	N	Seizures
Y	N	Fainting Spells	Y	N	Shingles
Y	N	Frequent Headaches	Y	N	Sickle Cell Disease / Traits
Y	N	Glaucoma	Y	N	Sinus Problems
Y	N	Hay Fever	Y	N	Stroke
Y	N	Heart Attack	Y	N	Thyroid Problems
Y	N	Heart Murmur	Y	N	Tuberculosis (TB)
Y	N	Heart Surgery	Y	N	Ulcers
Y	N	Hemophilia	Y	N	Venereal Disease

Please list any serious medical condition(s) that you have ever had:

______

______

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Erythromycin	Y	N	Tetracycline
Y	N	Codeine	Y	N	Latex	Y	N	Other
Y	N	Dental Anesthetics	Y	N	Penicillin			

Please list any other drugs/materials that you are allergic to: ______

______

6 DENTAL HISTORY

Why have you come to the dentist today? ______

______

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

Are you currently in pain? ❑ Yes ❑ No

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

Have you ever had gum treatment? ❑ Yes ❑ No

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

Your current dental health is ❑ Good ❑ Fair ❑ Poor

Do you like your smile? ❑ Y ❑ N Do your gums ever bleed? ❑ Yes ❑ No

How many times a week do you floss?_____a day do you brush? _____

Type of bristles? ❑ Soft ❑ Medium ❑ Hard

How long do you use a toothbrush before replacing it? ______

Are your teeth sensitive to heat, cold, or anything else? ______

Have you lost any teeth? ❑ Yes ❑ No If yes, why? ______

7 FINANCIAL RESPONSIBILITY

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered.
I have read all the information on both sides of this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

1. ( ) CASH PAYMENT AT CONCLUSION OF EACH VISIT
2. ( ) CHECK PAYMENT AT CONCLUSION OF EACH VISIT
3. ( ) VISA, MASTERCARD, DISCOVER
4. ( ) CO-PAYMENT AT CONCLUSION OF EACH VISIT
5. ( ) CARE CREDIT LOAN IF APPROVED

We are pleased to offer these payment options to assist you in meeting your dental health care needs.

______
Signature Date

Cancer/or Bone Denisty Drugs (bisphosphonate Drugs)

Please initial any of the drugs listed below that you have taken in the past 10 years.

• Intravenous
- ___ Etidronate (Didronel®)
- ___ Pamidronate (Aredia®)
- ___ Ibandronate (Boniva®)
- ___ Zoledronate (Zometa®)
- ___ Clodronate (Bonefos®)

• Oral
- ___ Etidronate (Didronel®)
- ___ Ibandronate (Boniva®)
- ___ Clodronate (Bonefos®)
- ___ Risedronate (Actonel®)
- ___ Tiludronate (Skelid®)
- ___ Alendronate (Fosamax®)

OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. Initials: ______ Date: ______

Doctor's Comments: ______

MEDICAL HISTORY UPDATE

I have read my medical history dated ______ and confirmed that it states past and present medical conditions. ______
Signature Date

I have read my medical history dated ______ and confirmed that it states past and present medical conditions. ______
Signature Date

I have read my medical history dated ______ and confirmed that it states past and present medical conditions. ______
Signature Date