Date _____

Welcome to our office. Please answer all questions. This information is confidential and will help us serve you better. If at any time you have any questions regarding your treatment, your appointments, or fees, please ask.

Name _____ Date of Birth _____

Name You Wish To Be Called _____ Cell Phone _____

Address _____ Home Phone _____

City _____ State _____ Zip Code _____

May we contact you via e-mail? Y / N E-mail Address _____

Preferred Method of Appointment Reminder: Text ☐ E-mail ☐ Phone ☐

Social Sec. # _____ Marital Status _____

Student _____ School _____

Employer _____ Address _____

Occupation _____ Work Phone _____ Ext. _____

Name of Spouse _____ Employer _____

Person Responsible for Payment _____

Address _____

Family Physician _____ Date of Last Medical Exam _____

Who Referred You to This Office _____

PLEASE INDICATE BELOW HOW YOU PREFER TO PAY FOR ANY BALANCE ON YOUR DENTAL TREATMENT

Cash _____ Personal Check _____ Credit Card _____

Insured Name _____ Insured Birth Date _____

Insured Soc. Sec. # _____ Policy Number _____

Employer Providing Insurance _____

Insurance Company Name _____

Other Insurance? _____

If yes, Insured Name _____ Insured Birth Date _____

Insured Soc. Sec. # _____

Employer Providing Insurance _____

Insurance Company Name _____

MEDICAL HISTORY

Please ✓ appropriate box

Have you ever had any of the following?

QUESTIONS	Yes	No
1. Are you in good health?	☐	☐
2. Under physicians care?	☐	☐
3. Hospitalized or serious illness?	☐	☐
4. Allergic to Novocaine?	☐	☐
5. Excess bleeding requiring special treatment	☐	☐
6. Do you smoke?	☐	☐
7. (Women) Are you pregnant?	☐	☐
8. (Women) Are you nursing?	☐	☐
9. (Women) Are you using birth control pills?	☐	☐
10. Have you ever been told that you need to pre-medicate before dental treatment?	☐	☐
11. Are you allergic to any drugs or medications?	☐	☐
If so, what? _____		
12. Are you currently taking any medications?	☐	☐
If so, what? _____		
_____		

CONDITIONS	Yes	No		Yes	No
Allergies	☐	☐	Heart Murmur	☐	☐
Anemia	☐	☐	High Blood Pressure	☐	☐
Hepatitis	☐	☐	Heart Trouble	☐	☐
Diabetes	☐	☐	Rheumatic Fever	☐	☐
Asthma/HF	☐	☐	Kidney/Liver	☐	☐
Epilepsy	☐	☐	Fainting Spells	☐	☐
Arthritis	☐	☐	Tuberculosis	☐	☐
Glaucoma	☐	☐	Cancer Treatment	☐	☐
Ulcer	☐	☐	Cardiac Pacemaker	☐	☐
Stroke	☐	☐	Artificial Heart Valves	☐	☐
HIV Pos.	☐	☐	Artificial Joints	☐	☐

DENTAL HISTORY

Please ✓ appropriate box

	Yes	No
1. Regular dental care?	☐	☐
2. Happy with appearance of teeth?	☐	☐
3. Would you like your teeth whitened?	☐	☐
4. Chew on both sides of mouth?	☐	☐
5. Teeth unusually sensitive to:		
Cold ☐ Sweets ☐		
Hot ☐ Biting Pressure ☐		
6. Frequent Headaches?	☐	☐
7. Bothered by injections?	☐	☐
8. Had complete mouth X-ray?	☐	☐

	Yes	No
9. Pleased with health of teeth?	☐	☐
10. Gums bleed when brushing?	☐	☐
11. Unusual swelling in mouth?	☐	☐
12. Unusual/frequent pain in:		
Teeth ☐ Jaw Joints ☐		
Jaws ☐ Ears ☐		
13. Do any teeth feel loose?	☐	☐
14. Have you worn braces?	☐	☐
15. Have you been told you have had periodontal disease?	☐	☐

16. What is the purpose of today's visit? _____

17. Date of last Dental Exam or visit? _____

18. I have received a copy of this office's Notice of Privacy Practices.

19. I have received a copy of this office's financial policy.

Signature _____ Date _____