

## Medical History

Do you smoke or use tobacco products? Yes  No  Do you have any metal rods, pins or implants? Yes  No

Are you currently taking any prescription or over the counter supplements? Yes  No

If yes please list medications: \_\_\_\_\_

### For Woman Only

Are you currently pregnant? Yes  No  Total Weeks #: \_\_\_\_\_ Are you nursing? Yes  No

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

Yes <input type="checkbox"/>	No <input type="checkbox"/>	Abnormal Bleeding	Yes <input type="checkbox"/>	No <input type="checkbox"/>	High Blood Pressure
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Alcohol/Drug Abuse	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Hospitalization for any reason
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Anemia	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Kidney Problems
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Artificial Bones/Joints/Valves	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Liver Disease
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Asthma	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Low Blood Pressure
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Blood Fusion	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Lupus
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Cancer/Chemotherapy	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Mitral Valve Prolapse
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Colitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Pacemaker
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Congenital Heart Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Psychiatric Problems
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Radiation Treatment
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Difficulty Breathing	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Rheumatic/ Scarlet fever
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Emphysema	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Seizures
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Fainting Spells	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Shingles
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Frequent Headaches	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Sickle Cell Disease/Traits
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Glaucoma	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Sinus Problems
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Hay Fever	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Stroke
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Heart Attack/Surgery	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Thyroid Problems
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Heart Murmur	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Tuberculosis (TB)
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Hepatitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Ulcers
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Herpes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Venereal Disease
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Fever Blister			

### Are you allergic to any of the following?

Yes <input type="checkbox"/>	No <input type="checkbox"/>	Aspirin	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Erythromycin	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Penicillin
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Codeine	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Metals	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Tetracycline
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Dental Anesthetic	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Latex	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Other

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

Reason for today's appointment: \_\_\_\_\_ Do you like your smile? Yes  No  Does your gums ever bleed? Yes  No

Type of toothbrush bristles?  Hard  Medium  Soft How many times do you brush in a week? \_\_\_\_\_

How many times do you floss in a week? \_\_\_\_\_ Are your teeth sensitive to hot or cold? Yes  No  Have you lost any of your teeth? Yes  No

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

I understand that the information that I have provided today is correct to the best of my knowledge. I understand that this information will be confidential, and I will inform the office if there's any change in my medical condition.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT** unless prior arrangements have been approved. If 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 authorize payment directly to this 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 the release of any information, including the diagnosis and records of treatment rendered to my insurance company.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# WELCOME

## Patient's Information

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_  
SS #: \_\_\_\_/\_\_\_\_/\_\_\_\_ Birthday: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_  Male  Female  Single  Married  Divorced  Other  
Home Address: \_\_\_\_\_  
Home# : (\_\_\_\_) \_\_\_\_/\_\_\_\_/\_\_\_\_ Work# : (\_\_\_\_) \_\_\_\_/\_\_\_\_/\_\_\_\_ Ext: \_\_\_\_ Cell# : (\_\_\_\_) \_\_\_\_/\_\_\_\_/\_\_\_\_  
DL#: \_\_\_\_\_ Email Address: \_\_\_\_\_  
Employer's Name/Address: \_\_\_\_\_ Occupation: \_\_\_\_\_  
How Long There: \_\_\_\_ Other Family Members Seen by Us: \_\_\_\_ Whom May We Thank for Referring You? \_\_\_\_\_  
Name of Previous/Current Dentist: \_\_\_\_\_ Dentist Phone #: (\_\_\_\_) \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last Dental Visit: \_\_\_\_/\_\_\_\_/\_\_\_\_ Name of Medical Physician: \_\_\_\_\_  
Physician's Phone#: (\_\_\_\_) \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Last Visit: \_\_\_\_/\_\_\_\_/\_\_\_\_ Are You Currently under Care of a Physician? Y  N   
Please Explain: \_\_\_\_\_

## Neighbor/Relative Not Living With You

His/Her Name: \_\_\_\_\_ Relation: \_\_\_\_\_  
Address: \_\_\_\_\_  
Cell #: (\_\_\_\_) \_\_\_\_/\_\_\_\_/\_\_\_\_ Home #: (\_\_\_\_) \_\_\_\_/\_\_\_\_/\_\_\_\_ Work #: (\_\_\_\_) \_\_\_\_/\_\_\_\_/\_\_\_\_

## Spouse Information

His/Her Name: \_\_\_\_\_ Employer: \_\_\_\_\_  
Birthday: \_\_\_\_/\_\_\_\_/\_\_\_\_ Work #: (\_\_\_\_) \_\_\_\_/\_\_\_\_/\_\_\_\_ Ext: \_\_\_\_ SS #: \_\_\_\_/\_\_\_\_/\_\_\_\_ DL #: \_\_\_\_\_

## Primary Insurance

Dental Coverage?  Yes  No Insurance Co. Name: \_\_\_\_\_ Group #: \_\_\_\_\_  
Insurance Co. Address: \_\_\_\_\_  
Insurance Co. Phone #: (\_\_\_\_) \_\_\_\_/\_\_\_\_/\_\_\_\_ Insured's Name: \_\_\_\_\_ Relation: \_\_\_\_\_  
Insured's Birthday: \_\_\_\_/\_\_\_\_/\_\_\_\_ Insured's ID #: \_\_\_\_\_ Insured's Employer: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_

## Secondary Insurance

Dental Coverage?  Yes  No Insurance Co. Name: \_\_\_\_\_ Group #: \_\_\_\_\_  
Insurance Co. Address: \_\_\_\_\_  
Insurance Co. Phone #: (\_\_\_\_) \_\_\_\_/\_\_\_\_/\_\_\_\_ Insured's Name: \_\_\_\_\_ Relation: \_\_\_\_\_  
Insured's Birthday: \_\_\_\_/\_\_\_\_/\_\_\_\_ Insured's ID #: \_\_\_\_\_ Insured's Employer: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_

