# 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.

## ABOUT YOU

Today's Date_____ E-Mail Address_____

**Name:**_____

I prefer to be called:_____

Male____ Female____

Birthdate_____SSN_____

Home Address:_____

_____

Primary Phone_____

Other Ph._____

**Employer**_____

Work Phone_____

How long there?_____Occupation_____

Other family members seen by us_____

_____

## Spouse Information

His / Her Name_____

Employer_____

Primary Phone_____

Work Phone_____Ext._____

Birth Date_____SSN_____

**Person Responsible For Account:**_____

Cell Phone #_____

Billing Address_____

_____

Relationship:_____

Birth Date_____SSN_____

## INSURANCE

Dental Coverage Yes No

Insurance Co. Name_____

Insurance Co. Address_____

_____

Insurance Co. Phone #_____

Group # (Plan, Local, or Policy #)_____

ID # _____

Insured's Name_____

Relationship_____

Insured's Birthdate___/___/___

Insured's SSN _____

Insured's Employer_____

Employer's address_____

_____

## SECONDARY INSURANCE

Medical Coverage Yes No Dental Coverage Yes No

Insurance Co. Name_____

Insurance Co. Address_____

_____

Insurance Co. Phone #_____

Group # (Plan, Local, or Policy #)_____

Insured's Name_____

Relationship_____

Insured's Birthdate___/___/___ Insured's SSN _____

Insured's Employer_____

Employer's address_____

_____

# MEDICAL HISTORY

Your current physical health is ____Good ___Fair ___Poor

Do you have a personal physician? yes_____ No_____

Are you currently under the care of a physician? _____

Please explain_____

Do you smoke or use tobacco in any other form? _____

Have you had any pins, rods, or implants?_____

Are you taking any prescription / over-the-counter drugs?

Please list each one:_____

_____

**For Women:** Are you taking birth control pills?_____

Are you pregnant? _____Yes _____No

Are you nursing? _____Yes _____No

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

| | |
|---|---|
| Y N Abnormal Bleeding | Y N Hepatitis A B C |
| 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 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 Disease | Y N Pacemaker |
| Y N Diabetes | Y N Psychiatric Problems |
| Y N Difficulty Breathing | Y N Radiation Treatment |
| Y N Emphysema | Y N Rheumatic Fever |
| | Y N Scarlet Fever |
| Y N Epilepsy | Y N Seizures |
| Y N Fainting Spells | Y N Shingles |
| Y N Frequent Headaches | Y N Sickle Cell Disease |
| 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 |

Have you ever been hospitalized for any reason?_____

_____

**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:

_____

_____

# DENTAL HISTORY

Have you been advised to take **PRE-MEDICATION** before dental treatment?

**YES_____ NO_____**

Are you taking medications for **OSTEOPORSIS?**

**YES_____ NO_____**

**Name of medication _____**

Do you take **BIPHOSPHONATES** for any medical condition?

**YES_____NO_____**

**Name of medication _____**

Have you ever had a serious / difficult problem associated with any previous dental work?

**YES_____NO_____**

_____

**Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)?_____**

Your current dental health is _____Good ____Fair ____Poor

_____

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

**X**_____

Signature Date

## Payment is due in full at the time of treatment

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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. In the event that my account needs to be sent to an outside collection agency, I am aware that a $25.00 processing fee will be added to my outstanding balance. I am also aware that there is a $25.00 fee for a missed appointment unless the office has been notified 24 hours in advance.

**X**_____

Signature Date