

# Welcome

## About You

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

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

**Name:** \_\_\_\_\_ I prefer to be called: \_\_\_\_\_  Male  Female  
Last First Mi Mr Mrs Ms Dr

Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Social Security #: \_\_\_\_\_  Single  Married  Divorced  Widowed  Separated

**Home Address:** \_\_\_\_\_  
Street City State Zip

Home Phone #: (\_\_\_\_) \_\_\_\_\_ Pager/Cell #: (\_\_\_\_) \_\_\_\_\_ Work Phone #: (\_\_\_\_) \_\_\_\_\_ Driver License #: \_\_\_\_\_

Where & When are best times to reach you? \_\_\_\_\_ Whom may we Thank for referring you? \_\_\_\_\_

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

**Employer:** \_\_\_\_\_ How long there? \_\_\_\_\_ Occupation: \_\_\_\_\_

Employers Address: \_\_\_\_\_  
Street City State Zip

### Neighbor or Relative not living with you

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

Address: \_\_\_\_\_  
Street City State Zip

### Person Responsible for Account if other than yourself

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Home Phone #: (\_\_\_\_) \_\_\_\_\_ Social Security #: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone #: (\_\_\_\_) \_\_\_\_\_ Drivers License #: \_\_\_\_\_

Billing Address: \_\_\_\_\_  
Street City State Zip

## Spouse Information

His / Her Name: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_ Social Security #: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone #: (\_\_\_\_) \_\_\_\_\_ Drivers License #: \_\_\_\_\_

## Insurance Information

**Primary Insurance** Medical Coverage?  Yes  No Dental Coverage  yes  No Orthodontic Coverage  yes  No

Insurance Co. Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Group # (Plan, Local or Policy #): \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_  
Street/PO Box City State Zip

Insured's Name: \_\_\_\_\_ Insured's Social Security #: \_\_\_\_\_ Insured's Birthdate: \_\_\_/\_\_\_/\_\_\_ Relation: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_ Employer's Address: \_\_\_\_\_  
Street/PO Box City State Zip

**Secondary Insurance** Medical Coverage?  Yes  No Dental Coverage  yes  No Orthodontic Coverage  yes  No

Insurance Co. Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Group # (Plan, Local or Policy #): \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_  
Street/PO Box City State Zip

Insured's Name: \_\_\_\_\_ Insured's Social Security #: \_\_\_\_\_ Insured's Birthdate: \_\_\_/\_\_\_/\_\_\_ Relation: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_ Employer's Address: \_\_\_\_\_  
Street City State Zip

## Dental History

Why have you come to the dentist today? \_\_\_\_\_  
 \_\_\_\_\_

Are you currently in pain?  Yes  No

Do you require antibiotics before dental treatment?  Yes  No

Have you experienced problems associated with any previous dental work?  Yes  No

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

You current dental health is  Good  Fair  Poor

Do you floss daily?  Yes  No Brush daily?  Yes  No

Type of bristles on your toothbrush  Hard  Medium  Soft

How long do you use a toothbrush before replacing it? \_\_\_\_\_

Do you use anything in addition to your brush and floss?  Yes  No

If yes, what? \_\_\_\_\_

Would you like fresher breath?  Yes  No Whiter teeth?  Yes  No

Do your gums ever bleed?  Yes  No Ever Itch?  Yes  No

Have you ever had periodontal disease?  Yes  No

Do you have mobility in your teeth?  Yes  No

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

Do you still have wisdom teeth?  Yes  No

if yes, why? \_\_\_\_\_

Previous / Present Dentist: \_\_\_\_\_ Last Visit Date: \_\_\_\_\_

Why did you leave your previous dentist? \_\_\_\_\_

What did you like most & least about any dentist you have seen? \_\_\_\_\_  
 \_\_\_\_\_

Are you happy with the way your smile looks?  Yes  No

if not, what would you change? \_\_\_\_\_  
 \_\_\_\_\_

## Medical History

Do you have a personal physician?  Yes  No

Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: (\_\_\_\_) \_\_\_\_\_ Date of last visit: \_\_\_\_\_

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

Are you allergic to any of the following?

Y N Aspirin	Y N Erythromycin	Y N Sedatives
Y N Barbiturates	Y N Jewelry / Metals	Y N Sulfa Drugs
Y N Codeine	Y N Latex	Y N Tetracycline
Y N Dental Anesthetics	Y N Penicillin	Y N Other

Please list additional drugs / materials that cause allergic reactions: \_\_\_\_\_  
 \_\_\_\_\_

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

Are you pregnant?  Unsure  Yes  No

Week #: \_\_\_\_\_ Are you nursing  Yes  No

**Are you taking any of the following?**

Y N Acetaminophen  
 Y N Antibiotics  
 Y N Antihistamines  
 Y N Aspirin

Y N Blood Thinners  
 Y N Blood Pressure  
 Y N Cold Remedies  
 Y N Digitalis/Heart Medication

Y N Insulin/Diabetes Drugs  
 Y N Nitroglycerin  
 Y N Recreational Drugs  
 Y N Steroids/Cortisone

Y N Thyroid Medicine  
 Y N Tranquilizers  
 Have you ever taken Phen-Fen? Also known as Redux or Pondimin  Yes  No

Are you taking any prescription, over-the-counter drugs, herbal remedies, vitamins or minerals not listed above?  Yes  No If yes, please list each one: \_\_\_\_\_

**Do you or have you experienced the following?**

Y N Abnormal Bleeding  
 Y N Alcohol Abuse  
 Y N Anemia  
 Y N Arthritis  
 Y N Artificial Bones/Joints  
 Y N Artificial Valves  
 Y N Asthma  
 Y N Blood Transfusion  
 Y N Cancer  
 Y N Chemotherapy  
 Y N Chicken Pox

Y N Colitis  
 Y N Congenital Heart Defect  
 Y N Diabetes  
 Y N Difficulty Breathing  
 Y N Drug Abuse  
 Y N Emphysema  
 Y N Epilepsy  
 Y N Fainting Spells  
 Y N Fever Blisters  
 Y N Glaucoma  
 Y N Hay Fever

Y N Headaches  
 Y N Heart Attack  
 Y N Heart Murmur  
 Y N Heart Surgery  
 Y N Hemophilia  
 Y N Hepatitis  
 Y N Herpes  
 Y N High Blood Pressure  
 Y N HIV+/AIDS  
 Y N Hospitalized for Any Reason  
 Y N Kidney Problems

Y N Liver Disease  
 Y N Low Blood pressure  
 Y N Lupus  
 Y N Mitral Valve Prolapse  
 Y N Pacemaker  
 Y N Persistent Cough  
 Y N Psychiatric Problems  
 Y N Radiation Treatment  
 Y N Rheumatic Fever  
 Y N Scarlet Fever  
 Y N Seizures

Y N Shingles  
 Y N Sickle Cell Disease  
 Y N Sinus Problems  
 Y N Steroid Therapy  
 Y N Stroke  
 Y N Thyroid Problems  
 Y N Tonsillitis  
 Y N Tuberculosis (TB)  
 Y N Ulcers  
 Y N Venereal Disease

Please list any serious medical condition(s) that you have experienced: \_\_\_\_\_