

WELCOME TO OUR PRACTICE

Date _____

__ Mr. __ Mrs. __ Ms. __ Dr. __ First Name _____ MI _____ Last Name _____

__ Male __ Female Birthdate _____ Age ____ SS# _____ E-mail _____

__ Single __ Married __ Widowed Go By Name _____

Home address _____ Eki _____ Ucv _____ \ kr _____

Hm# (____) _____ Wk# (____) _____ Ext _____ Cell# (____) _____

Employer _____ Address _____

Referred by _____ Other family members seen by us _____

Spouse name _____ Employer _____ Wk# (____) _____

Spouse ss# _____ Spouse birthdate _____

DO YOU HAVE DENTAL INSURANCE? __ Yes __ No (Medicare does not cover dental procedures)

PRIMARY DENTAL INSURANCE

Insurance company name _____ Group # _____

Insurance company address _____

Insurance company phone (____) _____ Who is the insured? __ self __ spouse __ mother __ father

SECONDARY DENTAL INSURANCE

Insurance company name _____ Group # _____

Insurance company address _____

Insurance company phone (____) _____ Who is the insured? __ self __ spouse __ mother __ father

In case of emergency contact: Name _____ Phone (____) _____

Medical doctor: Name _____ Phone (____) _____

MEDICAL HISTORY

To our patients: Although dentists primarily treat the area in and around your mouth, it is a part of your entire body. Health problems that you may have or medication that you may be taking could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

For women:

Are you using a prescribed method of birth control? ____yes ____no Are you pregnant? ____yes ____no
Expected delivery date _____ Nursing? ____yes ____no

Women note: Antibiotics (such as penicillin) may alter the effectiveness of birth control. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

Have you had or do you currently have (include dates):

<input type="checkbox"/> Abnormal Bleeding/Hemophilia	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Alcohol/Drug Abuse	<input type="checkbox"/> Low Blood Pressure
<input type="checkbox"/> Anemia	<input type="checkbox"/> Lupus
<input type="checkbox"/> Artificial Bones/Joints/Valves	<input type="checkbox"/> Mental Health Problems
<input type="checkbox"/> Asthma	<input type="checkbox"/> Mitral Valve Prolapse
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Cancer/Chemotherapy	<input type="checkbox"/> Pain/Clicking in Jaw(s)
<input type="checkbox"/> Colitis	<input type="checkbox"/> Radiation Treatment
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Rheumatic/Scarlet Fever
<input type="checkbox"/> Difficult Breathing/Other Lung Problems	<input type="checkbox"/> Seizures
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Shingles
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Snoring/Sleep Apnea
<input type="checkbox"/> Fainting Spells	<input type="checkbox"/> Stroke
<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Tobacco Use
<input type="checkbox"/> Heart Attack/Surgery	<input type="checkbox"/> Tuberculosis (TB)
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Hepatitis	Other _____
<input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> HIV/Aids	
<input type="checkbox"/> Kidney Problems	

MEDICATION

Are you currently taking:

Any kind of medication, drug, pills? ____yes ____no
Blood Thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko Biloba)? ____yes ____no
Have you ever taken diet pills? ____yes ____no What kind? _____ When? _____
Any natural product, herbal supplement or homeopathic remedy? ____yes ____no
Any bone density medication (Aredia, Zometa, Fosamax, Actonel, Boniva) ____yes ____no

Please list all medications that you are currently taking:

ALLERGIES

Are you allergic to or had a reaction to:

- ☐ Local Anesthetic (numbing medication)
☐ Penicillin
☐ Erythromycin
☐ Other Antibiotics (if yes, please list) _____
☐ Sulfa Drugs
☐ Valium
☐ Aspirin
☐ Codeine or other narcotics
☐ Other Medications (if yes, please list) _____
☐ Latex
☐ Sulfites
☐ Tetracycline
☐ Nuts

Would you like to discuss anything with the dentist in private? ☐no ☐yes

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

Signature

Date

I understand that I am responsible for payment of services rendered and also responsible for paying any amount that my insurance does not cover. I hereby authorize my insurance company to make payment directly to this dental office.

Signature

Date

12/20/07