

# 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.

## REGISTRATION INFORMATION

Patient Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
Last First MI

Male  Female  Married  Divorced  Widowed  Separated

Birthdate: \_\_\_/\_\_\_/\_\_\_ Social Security #: \_\_\_\_\_ Age: \_\_\_\_\_

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

Phone (Home): \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

How Long There? \_\_\_\_\_ Occupation: \_\_\_\_\_

Where & when are the best times to reach you? \_\_\_\_\_

**Whom may we Thank for referring you?** \_\_\_\_\_

Other family members of your immediate family who are patients in our office: \_\_\_\_\_

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

## SPOUSE INFORMATION

His/Her Name: \_\_\_\_\_

Employer: \_\_\_\_\_

Birthdate: \_\_\_/\_\_\_/\_\_\_ Social Security #: \_\_\_\_\_ Age: \_\_\_ DL #: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

**PERSON RESPONSIBLE FOR ACCOUNT:** \_\_\_\_\_

Phone (Home): \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

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

Relation: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Employer: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

**DENTAL INSURANCE**

**Primary Dental Insurance**

Insurance Company Name: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Insurance Company Phone #: \_\_\_\_\_

Group # (Plan, Local or Policy): \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Insured's Date of Birth: \_\_\_/\_\_\_/\_\_\_ Insured's ID#: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

**Secondary Dental Insurance**

Insurance Company Name: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Insurance Company Phone #: \_\_\_\_\_

Group # (Plan, Local or Policy): \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Insured's Date of Birth: \_\_\_/\_\_\_/\_\_\_ Insured's ID#: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

**MEDICAL HISTORY**

Do you have a personal physician?  Yes  No

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

Phone #: \_\_\_\_\_ Last Visit Date: \_\_\_\_\_

Are you currently under the care of a physician? \_\_\_ Yes \_\_\_ No

Please Explain: \_\_\_\_\_

**In the event of an emergency, is there someone who lives near you that we should contact?**

His / Her Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Work #: \_\_\_\_\_ Home #: \_\_\_\_\_

**MEDICAL HISTORY, continued**

Your Current Physical Health is:  Good  Fair  Poor

Do you smoke or use tobacco in any form:  Yes  No

Are you taking any prescription/over the counter or herbal supplement drugs?:  Yes  No

Please list each one: \_\_\_\_\_

Have you ever taken Fosamax, or any other bisphosphonate?  Yes  No

Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath?  Yes  No

<b>For Women:</b> Are you using a prescribed method of birth control?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you nursing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		Week #: _____

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

- |  |   |
|--|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Bleeding                  | <input type="checkbox"/> Y <input type="checkbox"/> N Herpes / Fever Blisters     |
| <input type="checkbox"/> Y <input type="checkbox"/> N Alcohol / Drug Abuse               | <input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure         |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia                             | <input type="checkbox"/> Y <input type="checkbox"/> N HIV+ / AIDS                 |
| <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis                          | <input type="checkbox"/> Y <input type="checkbox"/> N Hospitalized for Any Reason |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial Bones / Joints / Valves | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney Problems             |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma                             | <input type="checkbox"/> Y <input type="checkbox"/> N Liver Disease               |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood Transfusion                  | <input type="checkbox"/> Y <input type="checkbox"/> N Low Blood Pressure          |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer / Chemotherapy              | <input type="checkbox"/> Y <input type="checkbox"/> N Lupus                       |
| <input type="checkbox"/> Y <input type="checkbox"/> N Colitis                            | <input type="checkbox"/> Y <input type="checkbox"/> N Mitral Valve Prolapse       |
| <input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Defect            | <input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker                   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes                           | <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric Treatment       |
| <input type="checkbox"/> Y <input type="checkbox"/> N Difficulty Breathing               | <input type="checkbox"/> Y <input type="checkbox"/> N Radiation Treatment         |
| <input type="checkbox"/> Y <input type="checkbox"/> N Emphysema                          | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic / Scarlet Fever   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy                           | <input type="checkbox"/> Y <input type="checkbox"/> N Seizures                    |
| <input type="checkbox"/> Y <input type="checkbox"/> N Fainting Spells                    | <input type="checkbox"/> Y <input type="checkbox"/> N Shingles                    |
| <input type="checkbox"/> Y <input type="checkbox"/> N Frequent Headaches                 | <input type="checkbox"/> Y <input type="checkbox"/> N Sickle Cell Disease         |
| <input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma                           | <input type="checkbox"/> Y <input type="checkbox"/> N Sinus Problems              |
| <input type="checkbox"/> Y <input type="checkbox"/> N Hay Fever                          | <input type="checkbox"/> Y <input type="checkbox"/> N Stroke                      |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Attack                       | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid Problems            |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur                       | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis (TB)           |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Surgery                      | <input type="checkbox"/> Y <input type="checkbox"/> N Ulcers                      |
| <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia                         | <input type="checkbox"/> Y <input type="checkbox"/> N Venereal Disease            |

Y  N Hepatitis

Please list any medical condition(s) that you have ever had:

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

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Aspirin            | <input type="checkbox"/> Y <input type="checkbox"/> N Erythromycin     | <input type="checkbox"/> Y <input type="checkbox"/> N Penicillin   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Codeine            | <input type="checkbox"/> Y <input type="checkbox"/> N Jewelry / Metals | <input type="checkbox"/> Y <input type="checkbox"/> N Tetracycline |
| <input type="checkbox"/> Y <input type="checkbox"/> N Dental Anesthetics | <input type="checkbox"/> Y <input type="checkbox"/> N Latex            | <input type="checkbox"/> Y <input type="checkbox"/> N Other        |

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

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**DENTAL HISTORY**

Why have you come to the dentist today?

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Has your doctor told you that you require antibiotics before dental treatment?

- Yes  No

Are you currently in pain?

- Yes  No

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

- Yes  No

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

- Yes  No

Your current dental health is?

- Good  Fair  Poor

Do you like your smile?

- Yes  No

Do your gums ever bleed?

- Yes  No

How many times a week do you floss?

\_\_\_\_\_

How many times a day do you brush?

\_\_\_\_\_

Type of bristles?

- Hard  Medium  Soft

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. I authorize the dental staff to perform and necessary dental services that I may need during diagnosis and treatment with my informed consent.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Payment is due in full at time of treatment unless prior arrangements have been approved.

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help.

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

**OFFICE USE ONLY**

I verbally reviewed the medical / dental information above with the patient named herein: Initials: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor's comments: \_\_\_\_\_

**MEDICAL HISTORY UPDATE**

1. Date: \_\_\_\_\_ Comments: \_\_\_\_\_ Signature: \_\_\_\_\_
2. Date: \_\_\_\_\_ Comments: \_\_\_\_\_ Signature: \_\_\_\_\_
3. Date: \_\_\_\_\_ Comments: \_\_\_\_\_ Signature: \_\_\_\_\_