WELCOME TO OUR PRACTICE

Patient Information

Name:_____ **DOB:**_____ **AGE:**_____
LAST FIRST MI

Nick Name:_____ ■**MALE** ☐**FEMALE**
NAME YOU WOULD LIKE TO BE CALLED

Home Address:_____ **DL#:**_____
STREET

_____ **SS#:**_____
CITY STATE ZIP

Mailing Address:_____ **Employer:**_____
(IF DIFFERENT) STREET

_____ **Work: (___)**_____
CITY STATE ZIP

E-Mail:_____

Phone: (___)_____ **Cell: (___)**_____ **Referred By**_____

Spouse's Information

Name:_____ **DOB:**_____ **AGE:**_____
LAST FIRST MI

Employer_____ **Work: (___)**_____ **DL#:**_____

E-Mail:_____ **SS#:**_____

Phone: (___)_____ **Cell: (___)**_____

Responsible Party Information

Name:_____ **DOB:**_____ **AGE:**_____
LAST FIRST MI

Mailing Address:_____ **DL#**_____
(IF DIFFERENT) STREET

_____ **SSN#**_____
CITY STATE ZIP

E-Mail:_____ **Employer**_____

Phone: (___)_____ **Cell: (___)**_____ **Work: (___)**_____

Insured Name_____ Insurance Co_____	Insured Name_____ Insurance Co_____
Insured Address_____ Insurance #_____	Insured Address_____ Insurance #_____
_____ Group#_____	_____ Group#_____
Insured SSN #_____ Relation to patient_____	Insured SSN #_____ Relation to patient_____
DOB	DOB

Dental Questions

What is the main concern with your teeth?_____

_____

_____

Are you currently in pain? □Y □N

Please Explain_____

How many times a week do you floss?_____

How many times a day do you brush?_____

What type of bristles? □HARD □MEDIUM □SOFT

Do you ever have any pain or tenderness in the jaw joint (TMJ/TMD)? □Y □ N

Do you have frequent or sever headaches? □Y □N

Do you like your smile? □Y □N

Do your gums ever bleed? □Y □N

Current Dentist:_____ Last Visit_____

Medical Questions

Physician:_____ Phone #_____ Last Visit:_____

Are you currently under the care of a Physician? □Y □N

Please describe your health: □GOOD □FAIR □POOR

Please list any medication/drugs you are currently taking:_____

_____

Please list any allergies to medications:_____

Are you allergic to any of the following?

□Y □ N Aspirin □Y □ N Erythromycin
□Y □N Codeine □Y □ N Dental Anesthetics
□Y □N Latex □Y □ N Tetracycline
□Y □N Penicillin □Y □ N Other:_____

Any of the following symptoms
REMOVE

□Y □ N Snoring
□Y □ N Witnessed apneas
□Y □N Excessive daytime sleepiness
□Y □ N Nocturnal choking
□Y □ N Unrefreshed sleep
□Y □ N Poor sleep suality
□Y □ N Insomnia
□Y □ N Morning headaches
□Y □ N Esophageal reflux
□Y □ N Impaired Memory
□Y □ N Nocturnia

Do you have any of the following diseases or medical problems?

□ Y □ N Prosthesis
□ Y □ N Heart Attack
□ Y □ N Cancer
□ Y □ N Diabetes
□ Y □ N HIV/AIDS
□ Y □ N Hemophilia
□ Y □ N Asthma
□ Y □ N Hepatitis
□ Y □ N Tuberculosis
□ Y □ N Shingles
□ Y □ N Fever Blister
□ Y □ N Venereal Dis
□ Y □ N Ulcers/Colitis
□ Y □ N Heart Murm
□ Y □ N Emphysema
□ Y □ N Sinus Probs

□ Y □ N Scarlet Fever
□ Y □ N Congenital Heart Def
□ Y □ N Convulsions/Epilepsy
□ Y □ N Abnormal Bleeding
□ Y □ N Artificial Valves
□ Y □ N Heart Surgery
□ Y □ N Any stays in the hospital
□ Y □ N Kidney/Liver Problems
□ Y □ N Hey/Freq Headaches
□ Y □ N Drug/Alcohol abuse
□ Y □ N Blood Transfusion
□ Y □ N Anemia
□ Y □ N Glaucoma
□ Y □ N Difficulty breathing
Other_____

_____

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

I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I also authorize the dental staff to perform the necessary dental services I may need.

_____

Signature Date

Payment is due time of service unless prior arrangements have been approved.

OFFICE USE ONLY:
I verbally reviewed the dental/medical information above with parent/guardian & patient named herein.
Initial_____ **Doctors Comments**_____