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Welcome To Our Practice

PATIENT INFORMATION:

Last Name:______________________________**First Name**:___________________________Preferred Name:______________________

Date of Birth:___________________**SSN**:______________________Sex: M F **Driver's License**:___________________________

E-mail Address:______________________________ Occupation:_____________________________________

Cell Phone:__________________________**Home Phone**:__________________________**Work Phone**:__________________________

Address:____City, State:______________________Zip Code:__________

Emergency Contact Name:_______________________**Phone #** :____________________**Relationship**:__________________________

Employer:______________________________Address, City, State, Zip____

Spouse Name:____ Occupation:____

Date of Birth:____________________SSN:______________________Sex: M F Driver's License:_________ __________________

Spouse's Employer:___________________________Address, City, State, Zip:____

Referral Information

: How did you hear about our office? Website____ Patient Referral____ Insurance Comp____Other_____
If you were referred, whom may we thank for their trust in us?____

INSURANCE INFORMATION:

Insured's Name:________________________________ **SSN**:_________________________**Date of Birth**:________________________

Primary Insurance Comp:____**Phone #:**________________________________

Group Number:__________________________________

Address:____City, State, zip:______________________________________

Do you have dual coverage? Yes No If yes, please complete the following Secondary Insurance information

Insured's Name:________________________________ **SSN**:__________________________**Date of Birth**:_______________________

Secondary Insurance Comp:____**Phone #**:_____________________________

Group Number:___________________________________

Address:____City, State, zip:_______________________________________

______ I hereby authorize assignment of my insurance benefits directly to the provider for services rendered. I understand that I am
Initials responsible for payment of services rendered and any co-payments and deductible that my insurance company does not cover.

______ The information that I have given today is correct to the best of my knowledge and I understand it is my responsibility to inform this
Initials office of any changes to the information I have provided.

Signed:_____________________________________**Date**:______________________**Relationship to Patient**:_______________________

Patient Name:____ **Date:**_________________________________

Medical History

I. Please answer each question. Circle YES or NO.

A. Are you in good health?.. Yes No
B. Have you ever been hospitalized?.. Yes No
If so, What was the problem?..
C. Are you under the care of a physician?.. Yes No
If so, what is the condition being treated?..
Name of your physician:_________________________________ **physician phone number:**____________________
D. Do you wear a cardiac pacemaker, or have you had heart surgery?..................... Yes No
E. Have you ever been premedicated with antibiotics for your dental treatment?.......... Yes No
F. Do you take or have taken any of the followings:
___Phen-Phen / Redux or any other diet drugs? ___Recreationa drugs (marijuana, cocaine, etc.) ___Tobacco in any forms

For Women

G. Are you taking birth control pills? Yes No
H. Are you pregnant? Yes No
If so, how many months?..
I. Are you nursing? Yes No

II. Do you have or have you had any of the following diseases, medical conditions or procedures?

1. Hepatitis, A B C	Y N	12. Tuberculoses(TB)	Y N	23. Drug Addiction	Y N
2. Seizures or Epilepsy	Y N	13. Herpes	Y N	24. VD (syphilis or gonorrhea)	Y N
3. High Blood Pressure	Y N	14. Diabetes	Y N	25. Cancer, Tumors	Y N
4. Heart Attack	Y N	15. Chicken Pox	Y N	26. Chemotherapy	Y N
5. Heart Murmur	Y N	16. Asthma	Y N	27. Radiation treatments	Y N
6. Mitral Valve Prolapse	Y N	17. Cold Sores	Y N	28. Implant(s)	Y N
7. Congenital Heart Lesions	Y N	18. Stroke	Y N	29. Arthritis/rheumatism	Y N
8. Chest Pains	Y N	19. Dry Mouth	Y N	30. Liver disease	Y N
9. HIV + or AIDS-ARC	Y N	20. Kidney disease	Y N	31. Anemia	Y N
10. Blood Transfusions	Y N	21. Sinus problem	Y N	32. Shingles	Y N
11. Swollen Ankles	Y N	22. Thyroid Disease	Y N	33. Juandice	Y N

III. Are you taking any blood thinning medications such as Aspirin, Coumadin, Plavix , etc.? Y N

IV. Are you allergic to any of the following:

Penicillin Y N Tetracycline Y N Sulfa Drugs Y N Latex Y N Codeine Y N Dental Anesthetics Y N
Metal Y N Aspirin Y N Other:____

V. Are you taking any medications? If so, please list:

1. ____________________ 2.____________________ 3.____________________ 4.____________________ 5.____________________

Dental History

A. Reason for today's visit? ☐ Exam ☐ Consultation ☐ Emergency, explain:__________________________________

B. Does dental treatment make you nervous? ☐ Slightly ☐ Moderately ☐ Extremely

C. Do you grind or clench your teeth? Y N D. Do your gums bleed when you brush? Y N E. Are your teeth sensitive to cold or hot? Y N

F. If you could change anything about your smile which of the following would you do?

Remove silver fillings___ Reshape/resize my teeth___ Close space or spaces___ Replace missing teeth___
Straighter teeth___ Replace old crowns___ Restore chipped teeth___ Less gum showing when smile___
Complete smile make over___

G. Former Dentist's Name:______________________________________Date of your last visit?______________________

Signature of PATIENT or GUARDIAN: ____**Date**:__________________________