Welcome to

About Dental Care

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.

About You

Today's Date: _____ Sex: ○M ○F

Name: _____
Last First M.I. Mr.Mrs.Ms.Dr.

I prefer to be called: _____

○Single ○Married ○Divorced ○Widowed ○Separated

Birthdate: _____ Age: _____ SS#: _____

DL#: _____ State: _____

Home Address: _____

_____

Mailing Address: _____

_____

Email: _____ Home#: _____

Cell#: _____ Work#: _____

Employer: _____

Employer Address: _____

_____

How Long There? _____ Occupation: _____

Best time and place to reach you? _____

How did you hear about us? _____

What is you favorite restaurant? _____

Other Family Members seen by us: _____

_____

Previous Dentist: _____

Last Dental Visit: _____

Spouse Information

Spouse's Name: _____

Birthdate: _____

Cell#: _____ Work#: _____

Employer: _____

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

Name: _____

Relationship: _____ Cell#: _____

Home#: _____ Work#: _____

Dental Insurance

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

_____

Insurance Co. Phone: _____

Group Plan: _____ Group#: _____

Insured's Name: _____

Relation to Insured: _____

Insured's Birthdate: _____ ID#: _____

Insured's Employer: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

_____

Insurance Co. Phone: _____

Group Plan: _____ Group#: _____

Insured's Name: _____

Relation to Insured: _____

Insured's Birthdate: _____ ID#: _____

Insured's Employer: _____

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

Continued on back of form.

In Office Use Only

Eff Date: _____ Dent Mx: _____ Indiv Mx: _____

IndivDeduct: _____ Fam: _____ Benefit Yr: _____

Prev: _____% RCT/P/OS Ded? Y N Exam: _____

Bas: _____% RCT/P/OS Ded? Y N Prophy: _____

Maj: _____% RCT/P/OS Ded? Y N BWX: _____

Missing Tooth Clause: ○Yes ○No FMX: _____

Waiting Period: ○Yes ○No Fluoride: _____

Post Comp covered: ○Yes ○No Sealants: _____

Notes: _____

_____

Medical History

Are you currently under the care of a Physician? ○Yes ○No

Please explain: _____

_____

Physician's Name: _____

Phone#: _____ Last visit: _____

Have you been hospitalized or had a serious illness within the past 5 years? ○Yes ○No

What is your current Physical Health? ○Good ○Fair ○Poor

Are you taking any prescription or other drugs? ○No

Please list each one: _____

_____ _____

_____ _____

_____ _____

Have you discontinued any medications on your own that you should be taking? ○Yes ○No

Are you allergic to any of the following: ○No

❑ Dental Anesthetics ❑ Clindamycin ❑ Latex
❑ Acetaminophen ❑ Codeine ❑ Morphine
❑ Aspirin ❑ Ibuprofen ❑ Penicillin

Please list any other drug allergies: _____

_____

Do you have, or have you had, any of the following: ○No

❑ Artificial Heart Valve
❑ Congenital Heart Defect
❑ Infective Endocarditis
❑ Cardiac Transplant
❑ Problem in a Heart Valve
❑ Artificial Joints
❑ AIDS/HIV
❑ Anemia
❑ Arthritis
❑ Asthma
❑ Autoimmune Disease
❑ Blood Transfusion
❑ Blood Disease
❑ Blood Thinners
❑ Bruise Easily
❑ Cancer
❑ Cardiovascular Disease
❑ Chemotherapy
❑ Colitis
❑ Congestive Heart Failure
❑ Cortisone/Steroids
❑ Diabetes
❑ Dizziness
❑ Emphysema
❑ Epilepsy/Seizures
❑ Excessive Bleeding
❑ Fainting
❑ Glaucoma
❑ Hay Fever
❑ Heart Attack
❑ Heart Murmur
❑ Hepatitis type ____
❑ High Blood Pressure
❑ Insulin
❑ Jaundice
❑ Kidney Disease
❑ Liver Disease
❑ Mental Disorder
❑ Nervous Disorder
❑ Osteoporosis
❑ Pacemaker
❑ Persistent Cough
❑ Prostate Problems
❑ Radiation Treatment
❑ Respiratory Problems
❑ Rheumatic Fever
❑ Sinus Problems
❑ Stent
❑ Stomach Problems
❑ Stroke
❑ Tuberculosis
❑ Tumors
❑ Ulcers
❑ Venereal/STDs

Do you have any disease, condition, or problem not listed above? ○Yes ○No _____

_____

_____

Have you ever taken Fosamax, Actonel, Boniva, or any other drugs used to decrease bone resorption? ○Yes ○No

What was the duration? _____

Have you ever used Phen-Fen or other diet suppression combination for weight loss? ○Yes ○No

Do you use tobacco products? ○Yes ○No

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

Are you nursing? ○Yes ○No

Are you pregnant? ○Yes ○No Week#: _____

Dental History

What is the purpose of your visit today? _____

_____

_____

Are you currently in pain? ○Yes ○No

Do you have pain from heat, cold, or sweets? ○Yes ○No

Do you have pain from biting or chewing? ○Yes ○No

Have you ever had a serious/difficult problem associated with any previous dental work? ○Yes ○No Please explain:

_____

_____

What is your current Dental Health? ○Good ○Fair ○Poor

Do you like your smile? ○Yes ○No

Are you happy with the way your teeth appear? ○Yes ○No

Do your gums ever bleed? ○Yes ○No

How many times a day do you Brush _____? Floss _____?

What type of bristles? ○Hard ○Med ○Soft

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

If Yes please explain: _____

_____

Do you clench/grind your teeth? ○Yes ○No

Do you oftentimes have difficulty opening and/or closing your mouth? ○Yes ○No

Do you frequently have headaches? ○Yes ○No

Do you have clicking or popping by your ears when you open or close your mouth? ○Yes ○No

Do you have difficulty or pain when chewing? ○Yes ○No

Does opening wide cause pain? ○Yes ○No

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 confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services, with my consent, that I may need during diagnosis and treatment. I also understand that if I opt for sleep dentistry that the dental staff may need to alter treatment without being able to discuss it with me and they promise to keep my best interests in mind when making those decisions.

_____

Signature (Patient or Parent if a minor). You will also be asked to sign this document electronically.