Date:______________________

Welcome to our office!  Please complete the following information.

## Demographic:

Name:____________________________________________ Sex: M/F Date of Birth:________________

Nickname:___________________________________________ Email: ________________________________

Address:___________________________________________________________________________________

City: _______________ State: _______ Zip: ______________ Social Security #:___________________________

Home phone#:_________________________ Work phone#:___________________Cel:______________________

Married: yes no Name of Spouse:________________________________________________________

Employer:_______________________________ Occupation:________________________________________

Work Address: ______________________________________________________________________________

Student:_________________________________ School:_________________________________________

## Current Medical Care & Previous Dentist Information

Family Physician and location:__________________________________________________________________

Previous Dentist and location:__________________________________________________________________

Date of last medical exam:__________________________ Date of last dental exam:____________________________

Who referred you to our office?:________________________________________________________________

## Dental Insurance and Payment Information

Person responsible for payment:________________________________________________________________

Address:___________________________________________________________________________________

Insured Name:____________________________________ Insured Birth Date:_______________________________

Insured Social Security #:___________________________ Policy Number:____________________________________

Employer providing insurance:__________________________________________________________________

Insurance Company Name:_______________________________________________________________________

Other Insurance? If so, please include the same information above:__________________________________________

______________________________________________________________________________________________

**Our Financial Policy:** Payment for dental treatment is due at the time of service.  If you have dental insurance, we will file your insurance for you when provided with your proper information.  Payment is still expected at the time of service to cover such items as deductibles, co-payments, etc.  We allow 60 days for your insurance company to make payment. After this time, all inquiries and payments due are the patient's responsibility.

# Medical History

✓ Please check yes for any of the following that apply to your health.

| | | | | | |
|---|---|---|---|---|---|
| Are you in good health? | ( ) | Allergies | ( ) | Artificial Heart Valve | ( ) |
| Anemia | ( ) | Heart Murmur | ( ) | High Blood Pressure | ( ) |
| Do you consume alcohol? | ( ) | Stents/Shunts | ( ) | Stroke | ( ) |
| Do you smoke? | ( ) | Hepatitis A,B,C | ( ) | Heart Trouble /Pacemaker | ( ) |
| Are you pregnant? | ( ) | Diabetes1or 2 | ( ) | Rheumatic Fever | ( ) |
| Experience excess bleeding? | ( ) | Asthma | ( ) | Kidney/Liver | ( ) |
| Are you allergic to latex? | ( ) | Epilepsy | ( ) | Fainting Spells | ( ) |
| Have you traveled abroad? | ( ) | Arthritis | ( ) | Tuberculosis | ( ) |
| Are you HIV positive? | ( ) | Glaucoma | ( ) | Sexually Transmitted Disease | ( ) |
| Dementia/ Alzheimer's | ( ) | Cancer | ( ) | Osteoporosis/Phosphonates | ( ) |

Are you under the care of a physician? If yes,

______________________________________________________________________________

What surgeries have you had? Please list:

______________________________________________________________________________

Have you had any joint replacement surgeries such as hip or knee? Please list ALL:

______________________________________________________________________________

Do you have any allergies to latex, drugs or anesthesia? Please list ALL:

______________________________________________________________________________

Have you been hospitalized? Please explain:

______________________________________________________________________________

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Do you take drugs, medications or supplements? Please list ALL:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Space for other health information and health history updates:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

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## Dental History

✓ Please check yes for any of the following that apply to your health.

| | | | |
|---|---|---|---|
| Have you had regular dental care? | ( ) | Do gums bleed when brushing? | ( ) |
| Any history of gum disease? | ( ) | Are your teeth unusually sensitive? | ( ) |
| Are you anxious about treatment? | ( ) | Do you have frequent jaw joint/muscle pain? | ( ) |
| Are you happy with the appearance of your teeth? | ( ) | | |

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I authorize the doctors and staff to perform dental treatment. I authorize the release of any information to provide for dental care and treatment.

Signature:_______________________________________ Date:_________________________________