

Date: \_\_\_\_\_



Welcome to our office! Please complete the following information.

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**Demographic Information:**

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: \_\_\_\_\_

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**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?	( )	Diabetes 1 or 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/Bisphosphonates	( )

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: \_\_\_\_\_

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?	( )		

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: \_\_\_\_\_