

Date: _____

Welcome to our office! Please complete the following information so we can take the best care of you as our patient.

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: _____

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 for any of the following that apply to your health:

Allergies	()	Trip to Emergency room?	()	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	()

How often do you see your physician?

Twice per year/Once per year

Explain _____

What surgeries have you had?

Please list: _____

Have you had any joint replacement surgeries such as hip or knee or breast implants?

Please list ALL: _____

Do you have any allergies to latex, drugs or anesthesia?

Please list ALL: _____

Have you been hospitalized?

Please explain: _____

Have you ever taken a group of drugs called bisphosphonates (ex. Fosamax) to increase your bone density? Other examples include Zometa, Reclast, Boniva, Actonel, and Prolia. YES/NO

If YES, for how long and when was your last dose? _____

Do you take drugs, medications or supplements or herbal supplements like garlic/ginseng/turmeric?

Please list ALL: _____

Space for other health information and health history updates:

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 dental specialists to provide for dental care and treatment or to medical personnel in case of a medical emergency.

Signature: _____

Date: _____