Welcome

CHART:

We want to help you have the brightest smile possible. Please fill out this form completely so we can know how to be help you reach maximum oral health.
The better we know you, the better we can care for you.

NAME: ☐ MALE ☐ FEMALE

BIRTHDATE: SS#: - -

STREET ADDRESS:

CITY: STATE: ZIP:

E-MAIL ADDRESS:

HOME PHONE: «HPhone» MOBILE:

OFFICE PHONE:

EMPLOYER: HOW LONG THERE?

EMPLOYER ADDRESS:

BEST TIME TO REACH YOU:

WHO MAY WE THANK FOR REFERRING YOU?

OTHER FAMILY MEMBERS SEEN BY US:

PREVIOUS DENTIST:

PHONE #: LAST VISIT THERE:

SPOUSE NAME:

BIRTHDATE:

MOBILE PHONE: SS#: - -

EMPLOYER ADDRESS:

OTHER PERSON RESPONSIBLE FOR ACCOUNT:

RELATIONSHIP:

EMPLOYER:

EMPLOYER PHONE:

DENTAL COVERAGE? ☐ YES ☐ NO

PRIMARY INSURANCE CO. NAME:

ADDRESS:

PHONE:

POLICY HOLDER'S NAME:

POLICY HOLDER'S BIRTHDATE:

SECONDARY DENTAL COVERAGE? ☐ YES ☐ NO

SECONDARY INSURANCE CO. NAME:

ADDRESS:

PHONE:

POLICY HOLDER'S NAME:

POLICY HOLDER'S BIRTHDATE:

DO YOU HAVE A PERSONAL PHYSICIAN? ☐ YES ☐ NO

PHYSICIAN NAME:

PHONE:

DATE OF LAST VISIT:

ARE YOU UNDER CARE OF THIS DOCTOR NOW?

EMERGENCY CONTACT:

RELATIONSHIP:

HOME PHONE: MOBILE:

STREET ADDRESS:

CITY: STATE: ZIP:

Welcome

CHART:

We want to help you have the brightest smile possible. Please fill out this form completely so we can know how to be help you reach maximum oral health.
The better we know you, the better we can care for you.

MY CURRENT HEALTH IS: ☐ GOOD ☐ FAIR ☐ POOR

HAVE YOU SMOKED OR USED TOBACCO IN ANY OTHER FORM? ☐ YES ☐ NO

HAVE YOU EVER HAD ANY METAL RODS, PINS OR IMPLANTS? ☐ YES ☐ NO

ARE YOU TAKING ANY PRESCRIPTION/OVER-THE-COUNTER OR HERBAL SUPPLEMENT DRUGS?

☐ YES ☐ NO **IF YES, PLEASE LIST BELOW:**

ARE YOU TAKING BIRTH CONTROL PILLS? ☐ YES ☐ NO

ARE YOU PREGNANT? ☐ YES ☐ NO
ARE YOU NURSING? ☐ YES ☐ NO

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

☐ ASPIRIN
☐ DENTAL ANESTHETICS
☐ JEWERLY/METALS
☐ PENICILLIN
☐ OTHER (**PLEASE LIST**):
☐ CODEINE
☐ ERYTHROMYCIN
☐ LATEX
☐ TETRACYCLIN

WHY HAVE YOU COME TO THE DENTIST TODAY?

HAVE YOU EVER TAKEN PHEN-PHEN? ALSO KNOWN AS REDUX & PONDIMIN?

☐ YES ☐ NO IF YES, WHEN?

DO YOU REQUIRE ANTIBIOTICS BEFORE DENTAL TREATMENT? ☐ YES ☐ NO

ARE YOU CURRENTLY IN PAIN? ☐ YES ☐ NO

HAVE YOU HAD A SERIOUS PROBLEM RELATED TO ANY PAST DENTAL WORK?
☐ YES ☐ NO IF YES, WHAT?

HAVE YOU EVER HAD GUM TREATMENT? ☐ YES ☐ NO

HAVE YOU EVER EXPERIENCED DISCOMFORT IN YOUR JAW (TMJ/TMD)?
☐ YES ☐ NO

DO YOUR GUMS EVER BLEED? ☐ YES ☐ NO

HOW MANY TIMES A WEEK DO YOU FLOSS?

HOW MANY TIMES A DAY DO YOU BRUSH?

TYPE OF BRISTLES? ☐ HARD ☐ MEDIUM ☐ SOFT

HOW OFTEN DO YOU REPLACE YOUR TOOTHBRUSH?

ARE YOUR TEETH SENSITIVE TO HEAT, COLD OR ANYTHING ELSE?
☐ YES ☐ NO

HAVE YOU LOST ANY TEETH? ☐ YES ☐ NO
IF YES, LIST CAUSE:

DO YOU LIKE YOUR SMILE? ☐ YES ☐ NO

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

☐ ABNORMAL BLEEDING/HEMOPHILIA
☐ AIDS/HIV
☐ ALCOHOL/DRUG ABUSE
☐ ANEMIA
☐ ARTHRITIS
☐ ARTIFICIAL BONES /JOINTS /VALVES
☐ ASTHMA
☐ BLOOD TRANSFUSION
☐ CANCER / CHEMOTHERAPY
☐ COLITIS
☐ CONGENITAL HEART DEFECT
☐ DIABETES
☐ DIFFICULTY BREATHING
☐ EMPHYSEMA
☐ EPLIEPSY / CONVULSIONS
☐ FAINTING SPELLS
☐ FREQUENT HEADACHES
☐ GLAUCOMA
☐ HAY FEVER
☐ HEART ATTACK / SURGERY
☐ HEART MURMUR
☐ HEPATITIS A B C
☐ HERPES / FEVER BLISTERS
☐ HIGH BLOOD PRESSURE
☐ HOSPITALIZED FOR ANY REASON
☐ KIDNEY PROBLEMS
☐ LIVER DISEASE
☐ LOW BLOOD PRESSURE
☐ LUPUS
☐ MITRAL VALVE PROLAPSE
☐ PACEMAKER
☐ PSYCHIATRIC PROBLEMS
☐ RADIATION TREATMENT
☐ RHEUMATIC / SCARLET FEVER
☐ SEIZURES
☐ SHINGLES
☐ SICKLE CELL DISEASE / TRAITS
☐ SINUS PROBLEMS
☐ STROKE
☐ THYROID PROBLEMS
☐ TUBERCULOSIS (TB)
☐ ULCERS
☐ VENEREAL DISEASE

ANYTHING YOU WOULD LIKE TO DISCUSS WITH THE DENTIST IN PRIVATE?
☐ YES ☐ NO

PLEASE LIST ANY OTHER SERIOUS MEDICAL CONDITION(S) THAT YOU HAVE HAD:

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.

SIGNATURE: **DATE:** / /

PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED. IF THIS OFFICE ACCEPTS INSURANCE, I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED AND ALSO RESPONSIBLE FOR PAYING ANY CO-PAYMENT AND DEDUCTIBLES THAT MY INSURANCE DOES NOT COVER. I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DENTAL OFFICE OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT. I HEREBY AUTHORIZE RELEASE OF ANY INFORMATION, INCLUDING THE DIAGNOSIS AND RECORDS OF TREATMENT OR EXAMINATION RENDERED, TO MY INSURANCE COMPANY.

SIGNATURE: **DATE:** / /