WELCOME TO OUR PRACTICE!

Please fill out completely and bring with you to the Consultation Appointment!
Our office advises that you should have your teeth cleaned prior to your scheduled Consultation!

Today's Date:_____ Name:_____

Home
Address:_____
City State Zip

DOB :_____ Age :_____ Home # :_____ Cell # :_____

Whom may we thank for referring you?_____ Work # :_____ Ext:_____

Other family seen by us:_____ E-Mail_____ SS # :_____

DL # :_____

Spouse Information

Name:_____

Employer:_____

Cell # :_____ Work # :_____

SS # :_____

DL #
:_____

DOB :_____ E-Mail_____

Employer Information

Name:_____
_

Address :_____

How long have you worked there? _____

When & Where are the best times to reach you? _____

_____
_

Occupation
:_____

Dental Information

Present/Previous Dentist :_____

Address :_____

_____
_

Phone # :_____

Last Visit :_____

Emergency Contact

Name :_____

Relation:_____
_

Home # :_____ Cell # :_____

Work # :_____ Ext. :_____

Primary Dental Insurance

Ins. Name
:_____

Ins. Address :_____

Ins. Phone #
:_____

Insured's
Name:_____

Relationship to Pt:_____

Insured's Employer:_____

Insured's DOB:_____

Insured's SS # :_____

Orthodontic Coverage: YES NO

Secondary Dental Insurance

Ins. Name
:_____

Ins. Address :_____

Ins. Phone #
:_____

Insured's
Name:_____

Relationship to Pt:_____

Insured's Employer:_____

Insured's DOB:_____

Insured's SS # :_____

Orthodontic Coverage: YES NO

Dental History

Why are you here today? _____

_____

_

Your current dental health is: GOOD FAIR POOR

Have you ever had a serious/difficult problem associated with previous dental work?
YES NO

Have you ever had any pain or tenderness in the jaw joint (TMJ/TMD)?
YES NO

Do you like your smile? 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? _____

Medical History

Do you have a personal physician? YES NO

Name:_____

_

Phone # :_____ Last Visit:_____

Your current physical health is: GOOD FAIR POOR

Are you currently under the care of a doctor? YES NO

If YES above, please explain:_____

_____

_

Are you currently taking any prescription or non-prescription drugs?

YES NO

Have you ever had any of the following diseases or medical problems?

Y N Prosthesis
Y N Heart Attack
Y N Cancer
Y N Diabetes
Y N Rheum. Fev.
Y N HIV+/AIDS
Y N Hemophilia
Y N Asthma
Y N Hepatitis
Y N Tuberculosis
Y N Shingles
Y N Fever Blister
Y N Venereal Dis.
Y N Ulcers/Colitis
Y N Heart Murm.
Y N Emphysema
Y N Sinus Probs.
Y N Other:_____

_____

Y N Hist. Of Scarlet Fev.
Y N Congenital Heart Def.
Y N Convulsions/Epilepsy
Y N Abnormal Bleeding
Y N Artificial Valves
Y N Heart Surg./Pacmkr.
Y N Kidney/Liver Probs.
Y N Mitral Valve Prolapse
Y N Artificial bones/joints
Y N Sev./Freq. Headaches
Y N Hi/Lo Blood Pressure
Y N Drug/Alcohol Abuse
Y N Blood Transfusion
Y N Anemia/Radiation Tmt.
Y N Glaucoma
Y N Difficulty Breathing
Y N Any Hospital Stays:

_____

_____

Are you allergic to any of the following?

Y N Aspirin
Y N Codeine
Y N Latex
Y N Penicillin
Y N Erythromycin
Y N Dental Anesthetics

Y N Tetracycline
Y N Other:_____

_____

_____

For Women Only

Are you taking birth control pills? YES NO

Are you pregnant? YES NO Week # :_____

Are you nursing? YES NO

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

I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I also authorize the dental staff to perform the necessary dental services I may need during treatment.

Signature:_____ Date:_____

PAYMENT IS DUE IN FULL AT TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.

*****OFFICE USE ONLY***OFFICE USE ONLY***OFFICE USE ONLY*****

I verbally reviewed the medical/dental information above with the parent/guardian and patient named herein.

Initials:_____ Date:_____ Doctor's comments:_____