

WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum

oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

1

ABOUT YOU

Today's Date: _____

E-mail Address: _____

Name: _____
LAST FIRST MI MR MRS MS DR

I prefer to be called: _____ Male Female

Birthdate: ___/___/___ Age: ___ SS #: _____

Home Address: _____
APT/CONDO #:

CITY STATE ZIP

Single Married Divorced Widowed Separated

Hm #: (____) _____ Pager / Cell #: _____

Wk #: (____) _____ Ext: ___ DL #: _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we Thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____
Please Circle

Last Visit Date: _____

2

SPOUSE INFORMATION

His / Her Name: _____

Employer: _____

Wk #: (____) _____ Ext: ___ SS #: _____

Birthdate: ___/___/___ Driver's License #: _____

Person Responsible for Account: _____

Wk #: (____) _____ Ext: ___ Hm #: (____) _____

Billing Address: _____

Relation: _____ SS #: _____

Employer: _____ DL #: _____

3

INSURANCE COVERAGE

Primary

Dental Coverage: Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's ID #: _____

Insured's Employer: _____

Secondary

Dental Coverage: Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's ID #: _____

Insured's Employer: _____

In the event of an emergency, is there someone who lives near you that we should contact?

His / Her Name: _____ Relation: _____

Wk #: (____) _____ Hm #: (____) _____

4

MEDICAL HISTORY

Do you have a personal physician? Yes No

Physician's Name: _____

Phone #: (____) _____ Date of last visit: _____

Are you currently under the care of a physician? Yes No

Please explain: _____

CONTINUED ON BACK

4

MEDICAL HISTORY continued

Your current physical health is: Good Fair Poor

Are you taking any prescription/ over-the-counter or herbal supplement drugs? Yes No

Please list each one: _____

Have you ever taken Fosamax, or any other bisphosphonate? Yes No

Have you ever taken Phen-fen? Yes No

For Women: Are you using a prescribed method of birth control? Yes No

Are you pregnant? Yes No Week #: _____

Are you nursing? Yes No

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

- Y N Abnormal Bleeding Y N Hepatitis
Y N Alcohol / Drug Abuse Y N Herpes / Fever Blisters
Y N Anemia Y N High Blood Pressure
Y N Arthritis Y N HIV+ / AIDS
Y N Artificial Bones / Joints / Valves Y N Hospitalized for Any Reason
Y N Asthma Y N Kidney Problems
Y N Blood Transfusion Y N Liver Disease
Y N Cancer /Chemotherapy Y N Low Blood Pressure
Y N Colitis Y N Mitral Valve Prolapse
Y N Congenital Heart Defect Y N Pacemaker
Y N Diabetes Y N Psychiatric Problems
Y N Difficulty Breathing Y N Radiation Treatment
Y N Emphysema Y N Rheumatic / Scarlet Fever
Y N Epilepsy Y N Seizures
Y N Fainting Spells Y N Shingles
Y N Frequent Headaches Y N Sickle Cell Disease / Traits
Y N Glaucoma Y N Sinus Problems
Y N Hay Fever Y N Stroke
Y N Heart Attack Y N Thyroid Problems
Y N Heart Murmur Y N Tuberculosis (TB)
Y N Heart Surgery Y N Ulcers
Y N Hemophilia Y N Venereal Disease

Please list any serious medical condition(s) that you have ever had: _____

Are you allergic to any of the following?

- Y N Aspirin Y N Erythromycin Y N Metals
Y N Codeine Y N Jewelry Y N Penicillin
Y N Dental Anesthetics Y N Latex Y N Tetracycline

Please list any other drugs/materials that you are allergic to: _____

5

DENTAL HISTORY

Why have you come to the dentist today?

Do you require antibiotics before dental treatment? Yes No

Are you currently in pain? Yes No Do your gums ever bleed? Yes No

Have you ever had a serious / difficult problem associated with any previous dental work? Yes No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? Yes No

Your current dental health is: Good Fair Poor

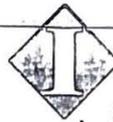
Do you like your smile? Yes No

Would you like whiter teeth? Yes No Fresher breath? Yes No

How many times a week do you floss? _____ a day do you brush? _____

Type of bristles? Soft Medium Hard

Do you smoke or use tobacco in any other form? Yes No



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. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

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.

Signature _____ Date _____

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

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. Initials: _____ Date: _____

Doctor's Comments: _____

MEDICAL HISTORY UPDATE

1. Date: _____ Comments: _____ Signature: _____

2. Date: _____ Comments: _____ Signature: _____

3. Date: _____ Comments: _____ Signature: _____

WELCOME

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.



Tell Us About Your Child

Today's Date: _____

Child's Name: _____
LAST FIRST MI

Nickname: _____ Male Female

Child's Birthdate: ____ / ____ / ____ Child's Age: ____

School: _____ Grade: _____

Child's Home #: (____) _____ SS #: _____

E-mail Address: _____

Child's Home Address: _____
APT/CONDO #

CITY STATE ZIP



Person Responsible For Account

Name: _____ Relation: _____

Billing Address: _____
CITY STATE ZIP

Hm #: (____) _____ DL #: _____

Employer: _____

Wk #: (____) _____ Ext: _____ SS #: _____

Who is responsible for making appointments?
 Name: _____

Wk #: (____) _____ Ext: _____ Hm #: (____) _____



Who Is Accompanying The Child Today?

Name: _____ Relation: _____

Do you have legal custody of this child? Yes No

Whom may we Thank for referring you? _____

Other family members seen by us: _____

 Previous / Present Dentist: _____

Last Visit Date: _____

Parent's Marital Status: Single Widowed Partnered
 Married Divorced Separated



Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

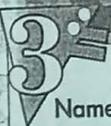
Relationship to Patient: _____

Policy Owner's Birthdate: ____ / ____ / ____ SS #: _____

Policy Owner's Employer: _____

Employer's Address: _____

Orthodontic Coverage? Yes No



Mother's Information: Step Mother Guardian

Name: _____ Birthdate: ____ / ____ / ____

Wk #: (____) _____ Ext: _____ Hm #: (____) _____

Employer: _____

SS #: _____ DL #: _____

Father's Information: Step Father Guardian

Name: _____ Birthdate: ____ / ____ / ____

Wk #: (____) _____ Ext: _____ Hm #: (____) _____

Employer: _____

SS #: _____ DL #: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ____ / ____ / ____ SS #: _____

Policy Owner's Employer: _____

Employer's Address: _____

Orthodontic Coverage? Yes No

6

Why did you bring the child to the dentist today? _____

Has the child ever had a serious/difficult problem associated with previous dental work? Yes No

Is the child's water fluoridated? Yes No

Is the child taking fluoridated supplements? Yes No

Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? Yes No

Does the child brush his/her teeth daily? Yes No

Floss his/her teeth daily? Yes No

Child's Physician: _____

Phone #: (____) _____ Date of Last Visit: _____

Is the child currently under the care of a physician? Yes No

Please describe the child's current physical health:
 Good Fair Poor

Has your child ever taken Phen-Fen? Yes No
(Also known as Redux or Pondimin) If so, when? _____

Please list all drugs that the child is currently taking:

Please list all drugs/materials that the child is allergic to:

Latex? Yes No Metals/Nickel? Yes No Plastic? Yes No

7

Has the child ever had any of the following medical problems?

- | | |
|--|--------------------------------|
| Y N Abnormal Bleeding | Y N Diabetes |
| Y N ADD / ADHD | Y N Handicaps / Disabilities |
| Y N Allergies to any drugs | Y N Hearing Impairment |
| Y N Any Hospital Stays | Y N Heart Murmur |
| Y N Any Operations | Y N Hemophilia |
| Y N Artificial Bones / Joints / Valves | Y N Hepatitis |
| Y N Asthma | Y N HIV+ / AIDS |
| Y N Cancer | Y N Kidney / Liver Problems |
| Y N Congenital Heart Defect | Y N Rheumatic / Scarlet Fever |
| Y N Convulsions / Epilepsy | Y N Sickle Cell Disease/Traits |
| | Y N Tuberculosis (TB) |

Please discuss any serious medical problems that the child has had: _____

8

Does/did the child have any of the following habits?

- | | |
|---------------------------|----------------------------|
| Y N Lip Sucking / Biting | Y N Nail Biting |
| Y N Nursing Bottle Habits | Y N Thumb / Finger Sucking |

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Neighbor or Relative not living with you.
 Name _____ Phone (____) _____
 Address _____
 City _____ State _____ Zip _____

9

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical

status. I authorize the dental staff to perform the necessary dental services my child may need.

Signature of parent or guardian _____ Date _____

The Parent or Guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the parent / guardian & patient named herein.
 Initials: _____ Date: _____
Doctor's Comments: _____

Medical History Update
1. Date: _____ **Signature:** _____
Comments: _____

2. Date: _____ **Signature:** _____
Comments: _____
