change your smile, change your life

Today's Date: ____/_____/______

1. ABOUT YOU

Name: ____
Last First M. Init

I prefer to be called: _________________________ ☐M ☐ F

Date of Birth: ________/________/_______ Age: _________

☐Single ☐Married ☐Widowed ☐Divorced ☐Separated

SS#: ____

HOME ADDRESS: ____________________________________

____
City State Zip

Cell#: ____

Home#: ____

Work #:________________________________ EXT: _______

Preferred Contact: ☐ *Home* ☐ *Cell* ☐ *Work*

Email: ____

Employer: ____

Years At Employer: _______ *Occupation:* _____________

General Dentist: ______________________________________

Last Visit/Treatment Rendered: ________________________

Family Members Seen By Us: ___________________________

How did you hear about our office?

☐ Referring Dental Office ☐ Previous Patient
☐ Google ☐ Yelp ☐ Other ___________________

Who may we Thank for Referring You?

____

2. SPOUSE INFORMATION

His/Her Name: _____________________________________

Spouse's Employer: _________________________________

Work #: ___________________________ EXT: __________

Spouse's SS#: ______________________________________

Spouse's Date of Birth: ______/______/______ Age: _______

3. PRIMARY DENTAL INSURANCE (we only file primary)

Insurance Co. Name: ________________________________

Insurance Co. Address: ______________________________

Insurance Co. Phone #: ______________________________

Member ID#: ______________________________________

Group #: ____

Insured's Name:____________________________________

Relationship To Patient:_____________________________

Insured's DOB: ________/_______/_______

Insured's SS #: _____________________________________

Insured's Employer:_________________________________

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

His/Her Name:_____________________________________

Relationship:__________________ Ph #:_________________

4. MEDICAL HISTORY

Your Current Physical Health Is:
☐ Good ☐ Fair ☐ Poor

Height ___________ **Weight** ___________

Do you have a personal physician? ☐ YES ☐ NO
Physician's Name:______________________________

Physician's Phone: ______________________________
Are you currently under the care of a physician?
☐ Yes ☐ No
Please explain:______________________________

Are you taking any prescription drugs?
☐ YES ☐ NO ☐ See List Attached
Please list each one: ______________________________

____

For Women:
Are you taking birth control pills? ☐ YES ☐ NO
Are you pregnant? ☐ YES Week# ______ ☐ NO
Are you nursing? ☐ YES ☐ NO

Have you ever had any of the following Diseases or medical problems?
☐Y ☐N Artificial Bones / Joints
☐Y ☐N Anemia
☐Y ☐N Artificial Valves
☐Y ☐N Arthritis
☐Y ☐N Asthma
☐Y ☐N Blood Transfusion
☐Y ☐N Congenital Heart Defect
☐Y ☐N Diabetes
☐Y ☐N Difficulty Breathing
☐Y ☐N Drug/Alcohol Abuse
☐Y ☐N Emphysema
☐Y ☐N Epilepsy/Seizure/Fainting Spells
☐Y ☐N Fever Blisters/Herpes
☐Y ☐N Heart Attack/Stroke
☐Y ☐N Heart Murmur
☐Y ☐N Hemophilia/Abnormal Bleeding
☐Y ☐N Hepatitis
☐Y ☐N HIV+ / AIDS
☐Y ☐N Kidney Problems
☐Y ☐N Mitral Valve Prolapse
☐Y ☐N Tuberculosis
☐Y ☐N Psychiatric Problems
☐Y ☐N Rheumatic/Scarlet Fever
☐Y ☐N Severe/Frequent Headaches
☐Y ☐N Shingles
☐Y ☐N Ulcers / Colitis
☐Y ☐N Sinus Problems
☐Y ☐N Cancer/Chemotherapy: ______________
☐Y ☐N Radiation Treatment: ______________
☐Y ☐N Hospitalized for any reason: ______________

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 Penicillin
☐Y ☐N Codeine
☐Y ☐N Tetracycline
☐Y ☐N Dental Anesthetics
☐Y ☐N Any Metal/Plastic
☐Y ☐N Erythromycin
☐Y ☐N Latex
☐Y ☐N Other ______________________________

5. DENTAL HISTORY
Your current dental health is: ☐Good ☐Fair ☐Poor

Do you require any antibiotics for dental treatments?
☐YES ☐NO

Do you like your smile? ☐YES ☐NO

Do your gums bleed? ☐YES ☐NO

Do you use any tobacco products? ☐YES ☐NO

Have you ever had an injury to your: ☐Mouth ☐Jaw

Do you have any missing or extra permanent teeth?
☐YES ☐NO

Have you ever had a serious/difficult problems with any previous dental work? ☐YES ☐NO

Have you ever experienced pain /discomfort in your jaw joint (TMJ/TMD)? ☐YES ☐NO

Have you been evaluated for orthodontic treatment?
☐YES ☐NO
Have you been let go from a dental practice as a patient?
☐YES ☐NO

What are your Main Dental Concerns that you would like to address in this appointment?

____

I understand the information that I have given today is correct to my best 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.

Patient / Guardian Signature: ______________________________ **Date:** __________