Personal Contact Information: **Date:** _______________

Name: (First) _______________ **(Middle Initial)** ______ **(Last):** ___________________

Preferred Name: ________________________ Please check**:** ( ) Male ( ) Female

Address: ________________________________ **Birthdate**: ______/_____/__________

________________________________ **SS#:** ___________________________

___________________(Zip)____________

Please check one: ( ) Single ( ) Married ( ) Significant Other ( ) Separated ( ) Widowed ( ) Child

Contact Information/Phone numbers: Please list any that apply:

(Home) ______________________ ( ) Best # to call ( ) Leave a message ( ) Do not call

(Work) _______________________ ( ) Best # to call ( ) Leave a message ( ) Do not call

(Cell) _______________________ ( ) Best # to call ( ) Leave a message ( ) Do not call

Email: ___________________@________________. **Com**

( ) I would like to receive appointment confirmations and other correspondence by email

Spouse/Significant Other/Parent Information:

Name: __________________________________ **( ) Male ( ) Female**

Please choose one of the following:

( ) We may share your dental care and appointments with this person

( ) DO NOT SHARE ANY INFO

( ) Share only the following info: ____

Phone # __________________________ Email: ___________________________

IN CASE OF EMERGENCY, CONTACT (If not listed above):

Name: __________________________________

Phone #'s: ____ Relationship: ________________

Financial Information:

Employer: ______________________________ Address: _____________________________________

Employer phone #: _________________________ ( ) **DO NOT CALL**

Do you have dental insurance coverage? If yes, please present the card upon check in or fill in the information below:

Insured person's name: ( ) You ( ) Other: _______________________________ (Relationship) _________

Insured person's Employer: ____________________________________

Insured person's birthdate: _____/_____/___________ Member ID # or SS# ______________________

Insurance Company Name: ____
Address: ____
____
__________________________ (Zip) ____________________

Phone Number: ___________________________________
Group #: ____________________________

Do you have secondary insurance coverage? If so, please provide the same information as above.

Insured person's name: ( ) You ( ) Other: _______________________________ (Relationship) _________

Insured person's Employer: ____________________________________

Insured person's birthdate: _____/_____/___________ Member ID # or SS# ______________________

Insurance Company Name: ____
Address: ____
____
__________________________ (Zip) ____________________

Phone Number: ___________________________________
Group #: ____________________________

Other Info:

How did you hear about our office?

- ( ) Another patient (Name): ____
- ( ) Internet search
- ( ) Other (Please describe):____

Dental History:

Approximate date of your last dental visit: ________________________ or ( ) Never been to dentist before

Reason for last dental visit: ( ) Routine exam/cleanings, etc ( ) Fillings/crowns/Extractions
( ) Other: ___________________________

Did you have your previous records sent to us: ( ) Yes ( ) No

If not, would you like for us to obtain your previous dental records? ( ) Yes ( ) No

Name of previous dental office: ___________________________________

City and State: ______________________________________

Reason for today's visit in our office:

( ) Establish care: exam, cleaning, and any applicable xrays

( ) Problem focused exam/Toothache/Broken tooth/Loose or missing tooth or restoration:

Please explain: ____

Have you ever had any problems with or reactions to any dental anesthetics? ( ) Yes ( ) No

If yes, name of anesthetic: ____________________________________

Describe your reaction:

( ) Heart palpitations ( ) Sweating/Nausea ( ) Difficulty breathing

( ) Rash or hives ( ) Prolonged anesthesia ( ) Difficulty getting numb

( ) Other: ____

How often do you brush? _______________/day

How often do you floss? ( ) Daily How often? ___________/day

( ) Weekly How often? ___________/week

( ) Occasionally (Describe: _________________________)

( ) Never

Please select all of the following topics you would like to dicuss:

( ) Whiter teeth ( ) Fresh breath ( ) Straighten teeth (Ortho)

( ) Close spaces/gaps ( ) Repair/replace existing work

( ) Grinding/clinching habit ( ) Other: ____

Do you wear an occlusal/night guard? ( ) Yes ( ) No

Any additional dental information you wish to share?

____

____

____

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____

<u>Medical History:</u>

Do you have a personal/general physician? ( ) Yes ( ) No

If yes, Physician's name: _________________________ Date of last visit: ____/____/______

Group/Practice Name: ____

Phone #: ____

Are you currently under the care of an additional physician, outside of routine physicals, exams, etc?

( ) Yes ( ) No

If yes, Please provide their info: Name: ____
Group/Practice Name: ____________________________
Phone #: ____
Reason: ____

Please provide their info: Name: ____
Group/Practice Name: ____________________________
Phone #: ____
Reason: ____

Please list any prescription medications, over the counter medications or supplements; birth control pills or devices, vitamins, or any other medicines you take on routine basis. Please include aspirin therapy.
****YOU MAY PROVIDE US WITH A LIST FOR OUR RECORDS** if this is more convenient. **

__________________________ ___________________________ __________________________
__________________________ ___________________________ __________________________
__________________________ ___________________________ ___________________________
__________________________ ___________________________ ___________________________
__________________________ ___________________________ ___________________________

Have you ever taken Fosamax or any other bisphosphonate therapy? ( ) YES ( ) NO

If this is an ongoing therapy, Please list name and frequency: __________________________________

Date of last treatment: _________________________________ ( ) NO LONGER TAKING

FOR WOMEN ONLY:

Are you pregnant? ( ) Yes ( ) No ( ) Possibly: ____________________________

If applicable, # of weeks pregnant: _________________________________
Any complications/concerns: ________________________________

Are you nursing? ( ) Yes ( ) No

Are you allergic to any of the following? Please check all that apply:

( ) Aspirin ( ) Dental Anesthetics ( ) Jewelry/Metals: ________________________________
( ) Ibuprofen ( ) Codeine ( ) Latex ( ) Plastics: ____________________
( ) Penicillin ( ) Erythromycin ( ) Sulfa ( ) Tetracycline

Please list any other drugs, foods, or materials that you are allergic to or have an adverse reaction to:
____
____
____

Have you ever had any of the following medical concerns or diseases? Explain if needed. Check all that apply:

( ) Abnormal Bleeding ________________	( ) Hemophilia	( ) Arthritis
( ) Blood Transfusion: ______________(dates)	( ) Congenital Heart Defect	( ) Glaucoma
( ) Anemia: ______________________	( ) Emphysema	( ) Hay Fever
( ) Sickle cell traits/disease: _______________	( ) Sinus problems	( ) Shingles
( ) Difficulty breathing: ___________________	( ) Hepatitis	( ) HIV/AIDS
( ) Drug/Alcohol Abuse: __________________	( ) Mitral Valve Prolapse	( ) Tuberculosis (TB)
( ) Kidney Problems: ____________________	( ) Heart murmur	( ) Psychiatric Problems
( ) Fainting/Dizziness: ___________________	( ) Rheumatic/Scarlet Fever	( ) Ulcers/Colitis

Do you have any artificial Bones/Joints/Valves: ( ) Yes ( ) No

Please explain with date it was placed: ____

____

____

____

DO YOU REQUIRE PRE-MEDICATION FOR DENTAL TX: ( ) Yes ( ) No

Have you ever had any type of Cancer? ( ) Yes ( ) No

If so, please explain type of cancer and treatment received (radiation, chemotherapy, etc):

____

____

____

Any ongoing treatment or concerns? ____

Have you ever experienced a Heart Attack/Stroke/AFIB or any type of heart disease? ( ) Yes ( ) No

If so, please explain with dates of incident(s): ____

____

Any additional concerns? ____

Do you have ( ) High or ( ) Low blood pressure? or ( ) Neither

Managed by: ( ) medications ( ) Diet/Exercise ( ) Other: ______________________________

Do you currently have or have you ever had Asthma? ( ) Yes ( ) No

If so, what type and is it currently controlled or no longer an issue: __________________________

____

Do you ever get cold sores? ( ) Yes ( ) No

Would you like a prescription to manage outbreaks? ( ) Yes ( ) No

Do you have an ( ) Underactive or ( ) Overactive thyroid? ( ) No

If so, how is it managed? ____

Do you have any respiratory problems or trouble breathing? ( ) Yes ( ) No

If yes, please explain: ____

Do you require Oxygen therapy? ____

Do you have Sleep Apnea/Sleep disorders/or snore? ( ) Yes ( ) No

If yes, please explain: ____

Do you smoke or use smokeless tobacco? ( ) Yes ( ) No

If yes, explain type and frequency: ____

If there's a previous history, how long has it been since you quit? ____________________________

Have you ever experienced acid reflux? ( ) Yes ( ) No ( ) Unsure

If yes, How often? ____

Do you experience headaches/migraines? ( ) Yes ( ) No

If yes, please explain: ____

Any other medical conditions or concerns not listed above? Please explain:

____
____
____
____
____
____
____

If you need additional space to list your medical providers for ongoing treatment, Please do so below:

Please provide their info: Name: ____

Group/Practice Name: _________________________

Phone #: ___________________________________

Reason: ____

Please provide their info: Name: ____

Group/Practice Name: ______________________________

Phone #: ____

Reason: ____