

# WELCOME TO OUR OFFICE!

Today's Date \_\_\_/\_\_\_/\_\_\_

Patient's Name: \_\_\_\_\_  Male  Female Date of Birth \_\_\_/\_\_\_/\_\_\_  
LAST FIRST INITIAL

How do you wish to be addressed? \_\_\_\_\_ Single  Married  Divorced  Widowed  Minor

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_

Home: ( ) \_\_\_\_\_ Pager, Cellular: ( ) \_\_\_\_\_ E-Mail: \_\_\_\_\_ @ \_\_\_\_\_

Patient's Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Whom may we thank for this referral: \_\_\_\_\_

## ACCOUNT AND INSURANCE INFORMATION

Person responsible for this account: (self if applicable): \_\_\_\_\_

Guarantor's Home Address (if different from above): \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_ Home: ( ) \_\_\_\_\_

Employer: \_\_\_\_\_

Business Address: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_

Bus Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

Guarantor's Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

### First Coverage

Employee Name: \_\_\_\_\_

Employee Date of Birth: \_\_\_\_\_

Employer: \_\_\_\_\_ #yrs \_\_\_\_\_

Insurance Co: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_

Policy or Group #: \_\_\_\_\_

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

### Second Coverage

Employee Name: \_\_\_\_\_

Employee Date of Birth: \_\_\_\_\_

Employer: \_\_\_\_\_ #yrs \_\_\_\_\_

Insurance Co: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_

Policy or Group #: \_\_\_\_\_

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

## ORAL HEALTH HISTORY

How can we help you today? \_\_\_\_\_

When was your last dental visit? \_\_\_\_\_ Why did you go? \_\_\_\_\_

Are there recent records/x-rays you would like us to transfer? \_\_\_\_\_

How do you take care of your teeth at home?  
\_\_\_\_\_

Children: What kind of fluoride vitamin or rinse are you using, if any? \_\_\_\_\_

Yes No

Do you have a history of fever blisters, "cold sores", mouth ulcers or herpes infections?

Do you have dry mouth frequently?

Do you notice clicking or popping noises in your jaw? Sore jaws or teeth? Headaches?

Do your gums ever bleed?

Do you ever experience bad breath or frequently have a bad taste in your mouth?

Have you ever wanted your teeth to be whiter?

If you could change anything about your teeth or smile, what would you change?  
\_\_\_\_\_

# HEALTH INFORMATION

Yes No

- In general, are you in good health?  
  Are you currently under a Physician's care? for? \_\_\_\_\_  
Physician: \_\_\_\_\_ Phys. Phone: ( ) \_\_\_\_\_  
Physician's Address: \_\_\_\_\_

## Do you have, or have you had, any of the following?

- Heart attack, pacemaker, artificial heart valve or heart surgery?  
  Heart murmur (leaky valve) or congenital heart disease?  
  High or low blood pressure?  
  Any blood disorder such as anemia or sickle cell disease?  
  Do you bleed excessively when you are cut?  
  Chest pain after mild exercise?  
  Asthma, emphysema or difficulty in breathing?  
  A persistent cough, sore throat or coughing up blood?  
  Any artificial bones or joints (prothesis) implanted? When? \_\_\_\_\_  
  Arthritis?  
  Gout?  
  Thyroid disease or surgery?  
  Kidney disease, renal dialysis?  
  Diabetes?  Juvenile Type I  Adult Type II  
  Hepatitis B or C, jaundice (yellow eyes or skin), liver disease?  
  Stomach or intestinal problems, ulcers, colitis or frequent diarrhea?  
  Cancer, chemotherapy or radiation therapy?  
  Seizures or fainting spells?  
  Psychiatric therapy?  
  Syphilis or any other venereal disease?  
  Positive antibody test to HIV? In contact with someone having Hepatitis, Tuberculosis or AIDS?

## Women:

- Are you pregnant or anticipating pregnancy in the near future?  
  Are you taking any hormones (including birth control pills)?

## Do you take any medications on a regular basis?

*(please list medications and dosages in the space provided or attach separate list)*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever taken "Fen-Phen" for weight loss?  Yes  No

## Are you allergic or have you had a bad reaction to any medications?

\_\_\_\_\_  
Reaction: \_\_\_\_\_  
\_\_\_\_\_  
Reaction: \_\_\_\_\_  
\_\_\_\_\_  
Reaction: \_\_\_\_\_

## Social and Family History

- Do you smoke? how many per day? \_\_\_\_\_ for how many years? \_\_\_\_\_  
  Do you have a history of alcohol or chemical dependency?  
  If yes, are you currently in treatment? How long? \_\_\_\_\_  
  Have you ever used cocaine, ecstasy or methamphetamines?  
  Does your family have a history of heart disease, diabetes, or any other disease?

*To the best of my knowledge, all of the preceding answers are true and correct.*

Patient's signature (or guardian if patient is a minor) \_\_\_\_\_

BP \_\_\_\_\_ Pulse \_\_\_\_\_ Respiration \_\_\_\_\_ Doctor: \_\_\_\_\_