

WELCOME



We are looking forward to having you join our great family of friends and patients. The benefits of a healthy, beautiful smile are immeasurable and our goal is to allow you to obtain the healthy teeth and attractive smile you want and deserve. Please complete this form so that we can provide the best care possible for you.

About You

Date: _____
Name: _____
I like to be called: _____
Home Address: _____
Zip: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ Email: _____
Date of birth: _____
Social Security Number: _____
Your employer: _____
Your occupation: _____
Marital status: Single Married Divorced Widowed
Spouse's name: _____
Best place to call you: _____ When: _____
In case of emergency, is there someone we can call?
Name: _____
Home Phone: _____ Other Phone: _____
Whom can we thank for referring you? _____

Insurance Information

Employee with insurance: _____
Date of birth: _____
Employee Social Security Number: _____
Employer: _____
Insurance company: _____
Group number: _____
Phone number: _____

Dental History

Why have you come to the dentist today? _____

Many patients consult us for a second opinion. Have you seen another dentist for your dental needs?
 No Yes *If yes, please explain:* _____

How would you describe the condition of your teeth and gums?
 Good Fair Poor
Are you currently in pain or discomfort with your teeth or gums?
 No Yes *If yes, please explain:* _____

The date of your last dental visit: _____
Previous dentist's name: _____
Have you ever had previous gum treatment? No Yes
If you could change anything about the appearance of your smile, what would you like to do? _____

If you could easily and safely whiten your teeth, would you be interested? Yes No
How often do you brush your teeth? _____
How often do you floss your teeth? _____
Do your gums bleed when you brush? Yes No
Do your gums bleed when you floss? Yes No
Have you ever been treated for TMJ symptoms?
 No Yes *If yes, please explain:* _____

Have you ever experienced pain in your jaw joint?
 Yes No
Do you grind your teeth? Yes No



Medical History

Name of Personal Physician: _____

Phone number: _____

Last visit with Physician: _____

Current health: Excellent Good Fair Poor

Do you smoke or use chewing tobacco? No Yes *If yes, how much per day?* _____

Are you currently taking prescription medications?

No Yes *If yes, please list below:*

<i>Name of medication</i>	<i>Purpose</i>
_____	_____
_____	_____

Have you ever taken Phenfen? No Yes

Have you had any serious medical problems within the past five years? No Yes *If yes, please explain:* _____

Have you ever had, or been treated for, any of the following diseases or medical problems?

- | | |
|----------------------------------|---------------------|
| Y N Heart Attack/Stroke | Y N Anemia |
| Y N Heart Murmur/Rheumatic Fever | Y N Diabetes |
| Y N Hepatitis/Jaundice | Y N AIDS/HIV |
| Y N Epilepsy/Seizures/Fainting | Y N Kidney Problems |
| Y N Cancer/Chemotherapy | Y N Tuberculosis |
| Y N Emotional Problems | |
| Y N High/Low Blood Pressure | |
| Y N Drug/Alcohol Abuse | |
| Y N Abnormal Bleeding | |

Have you been treated for any other illnesses not listed above?

No Yes *If yes, Please explain:* _____

Are you allergic to any medications? _____

Do you need to be pre-medicated before dental treatment? No Yes Don't know

Have you or are you receiving any drugs in your veins, such as Aredia or Zometa (biophosphonate drugs)? No Yes

For Women:

Are you pregnant? No Yes *If yes, how many months?* _____

Do you plan on becoming pregnant in the near future and, if so, when? _____

I understand that the information is correct to the best of my knowledge. I understand it will be held in the strictest confidence and only be used to improve communication between the doctor and myself. I also give permission for the doctor and his staff to use any photos he may take to be used for lecturing or for education purposes.

Signature

Date