We Would Like to Get to Know You Better!

Today's Date:____________________

Name: (Last) ____________________ (Middle Initial)______ (First)____________________ Birthdate: ________________

Parents Name (if minor) ____

Address:____ City:__________________ State: _______ Zip:____________

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced Social Security Number: ____________________

Telephone: (home)_________________ (Cell/Work)____________________ Email: __________________________

Occupation:______________________________ Employed By:____

Employer's Address:_________________________________ City:__________________ State: _______ Zip:____________

Are you a full time student? ☐ Yes ☐ No If Yes, What school? ____

Referred by: ☐ Friend/Patient: __________________ ☐ Insurance Plan: _______________ ☐ Location ☐ Internet ☐ Ad/Flyer

Person to notify in an emergency (not living with you)______________________________ Phone: ____________________

We Want to Take Care of Your Concerns and Needs First

Name of previous Dentist ____

When was your last dental appointment? ____

What are your present dental problems?____

Do you avoid brushing any part of your mouth?		☐ Yes	☐ No	
Do your gums bleed when brushing?		☐ Yes	☐ No	
Are your teeth sensitive to sweets, hot/cold, or biting pressure		☐ Yes	☐ No	
Are you dissatisfied with your teeth and their appearance?		☐ Yes	☐ No	
Does dental treatment make you nervous?	☐ Very	☐ Moderately	☐ Slightly	☐ No
I think my dental health is…	☐ Excellent	☐ Good	☐Fair	☐ Poor
If I could change my smile I would make my teeth	☐ Whiter	☐ Straighter	☐ Close Space	☐Repair Chips

Other concerns/needs of mine are:____

For Insurance Purposes

Primary Policy Holder is: ☐ Self ☐ Husband ☐ Wife ☐Mother ☐ Father

Name of Policy Holder:____ Policy holder SSN#:______________________

Policy holder's Date of Birth:____________ Employer:_________________ Name of Ins. Co:_________________________

Insurance Co. Phone #:________________ Group #:____________ Ins. Co. Address:_______________________________

*** Are you covered by a second insurance company? ☐ Yes ☐ No If yes, please complete the following…**

Name of Policy Holder:___________________________________ Policy Holder SSN#:_________-_______-_______

Policy Holder's Date of Birth:____________ Employer:___________________Name of Ins. Co:____________________

Insurance Co. Phone #:________________ Group #:____________ Ins. Co. Address:__________________________

Medical History

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

Physician's Name: ____________________

Physician's Phone: ____________________

Date of Last Physical: ____________________ Height: __________ Weight: ____________

(women) Are you pregnant? ☐ Yes ☐ No Due Date: ____________ Are you nursing? ☐ Yes ☐ No

Reason for requesting dental care: ________________________________

DIRECTIONS :Have you had any of the following? Answer all questions & blanks completely. Answers to the following questions are for our records & will be considered confidential.

	Yes	No			Yes	No			Yes	No			Yes	No	
1.	☐	☐	Heart Problems	11.	☐	☐	Respiratory Problems	21.	☐	☐	Smoker	31.	☐	☐	Mental Disorders
2.	☐	☐	High Blood Pressure	12.	☐	☐	Radiation Therapy	22.	☐	☐	Asthma	32.	☐	☐	Nervous Problems
3.	☐	☐	Low Blood Pressure	13.	☐	☐	Cancer	23.	☐	☐	Epilepsy	33.	☐	☐	Kidney Disease
4.	☐	☐	Circulatory Problems	14.	☐	☐	Arthritis	24.	☐	☐	Back Problems	34.	☐	☐	Tuberculosis
5.	☐	☐	Heart Murmur	15.	☐	☐	Glaucoma	25.	☐	☐	Sinus Problems	35.	☐	☐	Diabetes
6.	☐	☐	Mitral Valve Prolpse	16.	☐	☐	Allergy to Pencillin	26.	☐	☐	A.I.D.S.	36.	☐	☐	Artificial Joint
7.	☐	☐	Heart Attack	17.	☐	☐	Allergy to Latex	27.	☐	☐	HIV Positive	37.	☐	☐	Excessive Bleeding
8.	☐	☐	Stroke	18.	☐	☐	Allergy to Anesthetics	28.	☐	☐	Venereal Disease	38.	☐	☐	Blood Disease
9.	☐	☐	Pacemaker	19.	☐	☐	Other Allergies	29.	☐	☐	Stomach Ulcer	39.	☐	☐	Hemophilia
10.	☐	☐	Hepatitis, Jaundice or Liver Disease	20.	☐	☐	Hospitalized Within Last 6 Months	30.	☐	☐	Swollen Neck Glands	40.	☐	☐	Taking Blood Thinners

If you answered yes to any of the previous questions, please elaborate in the space below:

____

____

____

Are you in good health? ☐ Yes ☐ No Have you ever responded adversely to medical or dental treatment? ☐ Yes ☐ No

List all medication being taken:
1.____________ For what condition?____________
2.____________ For what condition?____________
3.____________ For what condition?____________
4.____________ For what condition?____________
5____________ For what condition?____________
(please use other side of this paper if you need more space to write)

I certify to the best of my knowledge that the above information is correct and that if there are any changes in the above, I agree to notify my dentist before my next visit.

Payment is due at the time services are rendered.

Signed: ____________________ Date: ____________________
signed by patient or parent if minor

Reviewed by: ____________________
Doctor Signature

The highest compliment our patients can give us is the referral of their friends and family. Thank you for your trust!