

# 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

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

I want to know about longer lasting solutions that may cost more  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.**

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

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)

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