WELCOME TO OUR PRACTICE

Date_____

__Mr. __Mrs. __Ms. __Dr. __ First Name _____ MI _____ Last Name _____

__Male __Female Birthdate _____ Age ___ SS# _____ E-mail _____

__Single __Married __Widowed Go By Name _____

Home address _____City_____State____Zip_____

Hm# (_____) _____ Wk# (_____) _____ Ext _____ Cell# (_____) _____

Employer _____ Address_____

Referred by _____ Other family members seen by us _____

Spouse name _____ Employer _____ Wk# (___)_____

Spouse ss# _____ Spouse birthdate _____

DO YOU HAVE DENTAL INSURANCE? ___Yes ___No (Medicare does not cover dental procedures)

PRIMARY DENTAL INSURANCE

Insurance company name _____ Group #_____

Insurance company address _____

Insurance company phone (____) _____ Who is the insured? ____self ____spouse ____mother ____father

SECONDARY DENTAL INSURANCE

Insurance company name _____ Group #_____

Insurance company address _____

Insurance company phone (____) _____ Who is the insured? ____self ____spouse ____mother ____father

In case of emergency contact: Name _____ Phone (___) _____

Medical doctor: Name _____Phone (___) _____

MEDICAL HISTORY

To our patients: Although dentists primarily treat the area in and around your mouth, it is a part of your entire body. Health problems that you may have or medication that you may be taking could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

For women:
Are you using a prescribed method of birth control? ___yes ___no Are you pregnant? ___yes ___no
Expected delivery date _____ Nursing? ___yes ___no
Women note: Antibiotics (such as penicillin) may alter the effectiveness of birth control. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

Have you had or do you currently have (include dates):

___Abnormal Bleeding/Hemophilia
___Alcohol/Drug Abuse
___Anemia
___Artificial Bones/Joints/Valves
___Asthma
___Blood Transfusion
___Cancer/Chemotherapy
___Colitis
___Diabetes
___Difficult Breathing/Other Lung Problems
___Emphysema
___Epilepsy
___Fainting Spells
___Frequent Headaches
___Glaucoma ___
___Heart Attack/Surgery
___Heart Murmur
___Hepatitis
___High Blood Pressure
___HIV/Aids
___Kidney Problems
___Liver Disease
___Low Blood Pressure
___Lupus
___Mental Health Problems
___Mitral Valve Prolapse
___Pacemaker
___Pain/Clicking in Jaw(s)
___Radiation Treatment
___Rheumatic/Scarlet Fever
___Seizures
___Shingles
___Snoring/Sleep Apnea
___Stroke
___Thyroid Problems
___Tobacco Use
___Tuberculosis (TB)
___Ulcers

Other_____

Do you need to take an antibiotic prior to dental treatment?___yes ___no

MEDICATION
Are you currently taking:
Any kind of medication, drug, pills? ___yes ___no
Blood Thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko Biloba)? ___yes ___no
Have you ever taken diet pills? ___yes ___no What kind? _____ When? _____
Any natural product, herbal supplement or homeopathic remedy? ___yes ___no
Any bone density medication (Aredia, Zometa, Fosamax, Actonel, Boniva) ___yes ___no

Please list all medications that you are currently taking:

ALLERGIES

Are you allergic to or had a reaction to:
___Local Anesthetic (numbing medication)
___Penicillin
___Erythromycin
___Other Antibiotics (if yes, please list) _____
___Sulfa Drugs
___Valium
___Aspirin
___Codeine or other narcotics
___Other Medications (if yes, please list) _____
___Latex
___Sulfites
___Tetracycline
___Nuts

Would you like to discuss anything with the dentist in private? ____no ____yes

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature Date

I understand that I am responsible for payment of services rendered and also responsible for paying any amount that my insurance does not cover. I hereby authorize my insurance company to make payment directly to this dental office.

Signature Date

12/20/07