# 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 liked 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 an 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 second opinions. Have you seen another dentist for your personal needs?

☐ No ☐ Yes *If yes, please explain:* ______________________________

______________________________

How would you describe the condition of your teeth or your gums? ☐Good ☐Fair ☐Poor

Are you currently in pain or discomfort with your teeth or gums?

☐ No ☐ Yes *If yes, please explain:*

Date of your last dental visit: ______________________________

Previous dentists 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? ☐ No ☐ Yes

How often do you brush your teeth? ______________________________

Do your gums bleed when you brush? ☐ No ☐ Yes

Do your gums bleed when you floss? ☐ No ☐ Yes

Have you ever been treated for TMJ symptoms?

☐ No ☐ *Yes If yes, please explain:* ______________________________

______________________________

Have you ever experienced pain in your jaw joint?

☐ No ☐ Yes

Do you grind your teeth? ☐ No ☐ Yes

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# 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:*

*Name of medication* *Purpose*

___________________________________________
___________________________________________
___________________________________________

Have you ever taken Phenfen? ☐ No ☐ Yes

Have you ever had any serious medical problems in 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 Heart Murmer/ Rheumatic Fever
- Y N Hepatitis/Jaundice
- Y N Epilepsy/Seizures/Fainting
- Y N Cancer/Chemotherapy
- Y N Emotional Problems
- Y N High/Low Blood Pressure
- Y N Drug/Alcohol Abuse
- Y N Abnormal Bleeding
- Y N Anemia
- Y N Diabetes
- Y N AIDS/HIV
- Y N Kidney Problems
- Y N Tuberculosis

Have you ever been treated for any 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?

___________________________________________

Dr. Preference ________________________________

Hygienist Preference ____________________________

I understand 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 and education purposes.

___________________________________________
Signature

___________________________________________
Date

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