WELCOME

Today's Date ________/______/________

Month Date Year

PERSONAL INFORMATION

Name ____________________, ____________________, ______ Title ________
Last First M.I. Suffix (Jr., etc.) (Mr., Ms., Dr., etc.)

Date of Birth ______/______/______ Social Security Number ______–______–______
Month Date Year

Address ____

City ____________________ State ____________ Zip Code ____________

Telephone: Home ______________ Work ______________ Cell ______________

E-mail address ____

Who should be notified in case of an emergency?

Name ____________________ Relationship ____________________

Telephone: Home ______________ Work ______________ Cell ______________

Who may we thank for referring you to our office? ____________________

INSURANCE INFORMATION

Are you covered by dental insurance? ❑Yes ❑No
If yes, Dental Insurance Company ____________________ Telephone ______________

Name of Insured ____________________ Social Security Number ______–______–______

Relationship ____________________ Date of Birth ______/______/______
Month Date Year

Employer ____________________ Group Number ______________

DENTAL HISTORY

1. Why have you come to the dentist today? ____________________
2. Do you have a toothache? ❑Yes ❑No
3. What was the approximate date of your last visit to the dentist? ______/______/______
Month Date Year
4. Are there recent X-rays of your teeth available? ❑Yes ❑No
If yes, where? ____________________
5. Have you ever had any trouble with dental treatment? ❑Yes ❑No
6. Do your gums ever bleed? ❑Yes ❑No
7. Do you clench or grind your teeth? ❑Yes ❑No
8. Do you use a soft toothbrush? ❑Yes ❑No
9. Have you had your wisdom teeth removed? ❑Yes ❑No
10. Would you like whiter teeth? ❑Yes ❑No
11. Do you participate in contact sports? ❑Yes ❑No
12. Are you concerned about bad breath? ❑Yes ❑No
13. Are you concerned about stained or darkened teeth? ❑Yes ❑No
14. What is your primary source of drinking water? ❑City ❑Well ❑Bottled
15. Do you have any other special concerns or questions? ____________________

____

MEDICAL INFORMATION

16. Do you have a personal physician? ❑Yes ❑No
If yes, Physician's Name ____________________ Telephone ______________
17. Approximate date of your last doctor's visit? ______/______/______

Last Modified: 30 April 2009

(continued on other side…)

Month *Date* *Year*

18. Are you in good health? ❑Yes ❑No
19. Have there been any changes in your health in the last year? ❑Yes ❑No
20. Have you ever had any **joint or heart valve replacement surgery**? ❑Yes ❑No
21. Do you smoke or use tobacco in any other form? ❑Yes ❑No
22. Have you taken any of these medications in the last six months?
    A. Cortisone or Other Steroids ❑Yes ❑No
    B. Anticoagulants (Blood Thinners) (Name ______________) ❑Yes ❑No
    C. Tranquilizers or Antidepressants (Name ______________) ❑Yes ❑No
23. Have you ever taken bisphosphonates (Fosamax, Actonel, Boniva)? ❑Yes ❑No
24. Are you taking medication of any kind? ❑Yes ❑No
    If yes, Please list ____
25. Have you ever taken any diet pills? ❑Yes ❑No
    If so, What? ____
26. Do you regularly take dietary supplements or herbal medications? ❑Yes ❑No

Garlic	❑Yes	❑No	>3g vitamin E	❑Yes	❑No
Ginger	❑Yes	❑No	St. John's Wort	❑Yes	❑No
Gingko	❑Yes	❑No	Kava	❑Yes	❑No
Ginseng	❑Yes	❑No	Valerian	❑Yes	❑No
>3g fish oil	❑Yes	❑No	Echinacea	❑Yes	❑No

Other ____

27. Have you ever had an allergic or unusual reaction to dental treatment? ❑Yes ❑No
28. Are you allergic to any of the following?

Penicillin	❑Yes	❑No	Sulfa Drugs	❑Yes	❑No
Erythromycin	❑Yes	❑No	Iodine	❑Yes	❑No
Codeine	❑Yes	❑No	Latex	❑Yes	❑No
Amoxicillin	❑Yes	❑No	Dental Anesthetic	❑Yes	❑No
Aspirin	❑Yes	❑No	Other ____________________	❑Yes	❑No

29. Have you ever had or been treated by a physician for any of the following conditions?

Abnormal Bleeding	❑Yes	❑No	Tuberculosis	❑Yes	❑No
Heart Attack/Stroke	❑Yes	❑No	Cancer or Tumor	❑Yes	❑No
High/Low Blood Pressure	❑Yes	❑No	Sinus Problems	❑Yes	❑No
Epilepsy/Seizures	❑Yes	❑No	Diabetes	❑Yes	❑No
Recent Weight Loss	❑Yes	❑No	Venereal Disease	❑Yes	❑No
Radiation Treatment	❑Yes	❑No	Ulcer	❑Yes	❑No
Heart Disease	❑Yes	❑No	Autoimmune Disease	❑Yes	❑No
Mitral Valve Prolapse	❑Yes	❑No	Respiratory Problems	❑Yes	❑No
Heart Pacemaker	❑Yes	❑No	Asthma	❑Yes	❑No
Circulatory Problems	❑Yes	❑No	Back Problems	❑Yes	❑No
Blood Disease	❑Yes	❑No	Frequent/Severe Headache	❑Yes	❑No
Hypoglycemia	❑Yes	❑No	Arthritis	❑Yes	❑No
Blood Transfusion	❑Yes	❑No	Kidney Problems	❑Yes	❑No
Hepatitis (Type ____)	❑Yes	❑No	Thyroid Disease	❑Yes	❑No
HIV+/AIDS	❑Yes	❑No	Glaucoma	❑Yes	❑No
Mental Illness	❑Yes	❑No	Chemical Dependency	❑Yes	❑No

30. Do you have any other serious medical condition not listed above? ❑Yes ❑No
    If yes, Please explain ____
31. Have any members of your immediate family been diagnosed with cancer, heart disease or diabetes? ❑Yes ❑No
    If yes, Who? ________________________________ Diagnosis __________________________
32. (Women) Do you suspect that you are pregnant? ❑Yes ❑No

The above information is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence. I agree to inform this office of any change in my medical status.

Signature ____ Date _______/______/_______

Month Date Year

I have received the letter “Welcome To Our Practice,” which explains office policies ________________

Initials