Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Today's Date_____ Referred By_____

Name_____ I prefer to be called_____
Last Name First Name Middle Initial

Address_____ City_____ Zip_____

Birthdate_____ Single_____ Married_____ Partner_____ Divorced_____ Widowed_____

Phone (H)_____ (W) _____ (Cell) _____

E-Mail Address_____

Appointment Confirmation Preference: **Home ☐ Work ☐ Cell ☐ None ☐**

Employer_____ Occupation_____

Soc. Sec.#_____ Driver's Lic.#_____

EMERGENCY CONTACT

Name_____ Relation_____

Phone (H)_____ (Cell) _____

PRIMARY INSURANCE

Responsible Party_____ Soc. Sec. #_____

Birthdate_____ Relation to Patient_____

Employer_____ Occupation_____

Insurance Carrier_____ Group#_____

SECONDARY INSURANCE

Responsible Party_____ Soc. Sec. #_____

Birthdate_____ Relation to Patient_____

Employer_____ Occupation_____

Insurance Carrier_____ Group#_____

PLEASE COMPLETE BOTH SIDES OF THIS FORM

DENTAL HISTORY

Do you require antibiotics before dental treatment? Yes No
If yes, which medication_____

Do you floss daily? Yes No Do you brush daily? Yes No

Are you currently in pain? Yes No

Are your teeth sensitive to heat, cold, or anything else?
_____

Do you or have you used tobacco products? Yes No

Do you or have you used Bisphosphonate? Yes No

Please list any dental issues or concerns we should be aware of:
_____

_____

Name of Previous Dentist_____

MEDICAL HISTORY

Physician's Name_____

Kaiser Number_____

List any prescription or over the counter drugs you're taking

_____

_____

FOR WOMEN:

Are you taking oral contraceptives? Yes No

Are you pregnant/trying? Yes No

Nursing? Yes No

Do you have or have you experienced the following? Please circle either Y or N:

Y N Abnormal Bleeding
Y N Alcohol Abuse
Y N Aids/HIV Positive
Y N Anemia
Y N Arthritis
Y N Artificial Heart Valve
Y N Artificial Joints
Y N Asthma
Y N Blood Transfusion
Y N Cancer
Y N Chemotherapy
Y N Chicken Pox
Y N Congenital Heart Defect

Y N Dental Anxiety
Y N Diabetes
Y N Difficulty Breathing
Y N Difficulty Hearing
Y N Drug Abuse
Y N Dry Mouth
Y N Emphysema
Y N Epilepsy
Y N Fainting Spells
Y N Fever Blisters
Y N Glaucoma
Y N Headaches
Y N Heart Attack

Y N Heart Murmur
Y N Heart Surgery
Y N Hemophilia
Y N Hepatitis
Y N High Blood Pressure
Y N High Gag Reflex
Y N Kidney Problems
Y N Liver Disease
Y N Low Blood Pressure
Y N Mitral Valve Prolapse
Y N Pacemaker
Y N Persistent Cough
Y N Psychiatric Problems

Y N Radiation Treatment
Y N Rheumatic Fever
Y N Sleep Apena
Y N Seizures
Y N Shingles
Y N Sinus Problems
Y N Stroke
Y N Thyroid Problems
Y N Tonsillitis
Y N Ulcers

Please list any serious medical condition(s) that you have experienced:_____

Are you allergic to any of the following? Please circle either Y or N:

Y N Aspirin
Y N Barbiturates
Y N Codeine

Y N Dental Anesthetics
Y N Jewelry / Metals
Y N Latex

Y N Penicillin
Y N Sedatives
Y N Sulfa Drugs

Y N Tetracycline
Y N Other
_____

I authorize the dental staff to perform the necessary dental services I may need. I affirm the information I have given is correct to the best of my knowledge. It will be used by the dentist to help determine appropriate and healthful dental treatment. It is my responsibility to inform this office of any changes in my medical status. I understand that I am financially responsible for all charges not paid by insurance. I understand that missed appointments and appointments cancelled without 24 hours' notice are subject to a $35 fee per appointment.

Signature of Patient or Guardian _____ Date _____

Doctor's Signature _____ Date_____

DATE	EXCEPTIONS	PATIENT'S SIGNATURE	REVIEWED BY
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Office Use Only:_____