TO OUR NEW PATIENTS: *IT'S NICE TO GET ACQUAINTED!*

PATIENT NAME:_____ BIRTHDATE:_____ M or F
NAME YOU PREFER TO BE CALLED:_____ SOCIAL SECURITY #: _____
MAILING ADDRESS:_____ ZIP:_____ PHONE:(H)_____
EMPLOYER: _____ PHONE:(W) _____ CELL: _____
SPOUSE/PARENT NAME: _____ SOCIAL SECURITY #: _____
SPOUSE/PARENT DOB:_____ SPOUSE/PARENT EMPLOYER: _____
PHONE: (H) _____(W)_____ CELL:_____ EMAIL:_____
WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

PLEASE CHECK THE PAYMENT METHOD YOU FIND MOST CONVENIENT:

___PAYMENT IN FULL AT TIME OF TREATMENT
(cash, debit or credit cards)
___VISA / MASTERCARD / DISCOVER

___DENTAL INSURANCE (REQUIRES DEDUCTIBLE AND/OR CO-PAY PERCENTAGE PER VISIT)
_____NAME OF INSURED
_____PLAN NAME / POLICY NUMBER
_____ID# FROM CARD
_____EMPLOYER NAME OF INSURED

Please describe your dental problem, if any _____
Date of last dental exam_____ Treatment performed _____
Date of last cleaning_____ Date of last dental visit_____
Is there anything you would change about the appearance of your teeth?_____
How frequently do you perform the following oral hygiene procedures? brushing?_____ flossing?_____
Y___N___Have you ever been treated for periodontal disease?
Y___N___Do your gums bleed when you brush_____? or floss_____?
Y___N___Have you ever had complications following previous dental treatment?
Y___N___Have you had orthodontic treatment (braces)?
Y___N___Do you ever have difficulty opening_____ or closing_____ your mouth?
Y___N___Do you notice popping on opening or closing your mouth?
Y___N___Do you have earaches_____, neckaches_____, ringing in your ears_____?
Y___N___Do you use tobacco? Type_____Frequency_____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:

Y___N___Acid Reflux
Y___N___ADD / ADHD (Circle one)
Y___N___Alzheimers
Y___N___Angina
Y___N___Any type of disability_____ explain
Y___N___Arthritis
Y___N___Artificial joint replacement
Y___N___Asthma
Y___N___Cancer
Type_____Date_____
Treatment_____
Y___N___Daytime Sleepiness
Y___N___Delayed healing
Y___N___Depression
Y___N___Diabetes Type I / Type II (Circle one)
Y___N___Fainting spells
Y___N___Hearing impaired
Y___N___Heart attack Date_____
Y___N___Heart murmur**
Y___N___Heart surgery Type_____
Y___N___Hepatitis A / B / C (Circle one)
Y___N___High Blood Pressure
Y___N___High Colesterol
Y___N___HIV positive / AIDS (Circle one)
Y___N___Kidney Failure
Y___N___Latex allergy
Y___N___Leukemia
Y___N___Liver disorders
Y___N___Low Blood Pressure
Y___N___Lung disorders
Y___N___Migraines
Y___N___Mitral valve prolapse
Y___N___Nervous disorders
Y___N___Osteoporosis
Y___N___Other heart or vascular disorders
Y___N___Pacemaker
Y___N___Prolonged bleeding
Y___N___Rheumatic fever
Y___N___Seizures
Y___N___Severe or frequent headaches
Y___N___Sinus disorders (medically treated)
Y___N___Snoring
Y___N___Stomach disorders
Y___N___Stroke Date_____
Y___N___Surgery
Type_____Date_____
Y___N___Thyroid disorders
Y___N___Tuberculosis (TB)
Y___N___Ulcers
Y___N___Vision impaired
Y___N___Wheelchair required
Y___N___(WOMEN) Are you pregnant?
Y___N___(WOMEN) Taking birth control pills?

(OVER) ➡

Do you take pre-medication for any reason prior to your appointment (i.e. heart disorder, heart surgery, joint replacement, etc) YES or NO. If so, why?_____

When was your last physical exam?_____
Name of your physician _____ Are you presently under his/her care?_____
Do you take aspirin daily?_____ Do you take Rx for osteoporosis?_____
Please list any medications you are currently taking (prescription / over-the-counter / herbal / recreational drugs)

_____

Please check any medications you are allergic to: None Known_____ Penicillin _____
Codeine____Sulpha____ Aspirin____ "Caine" anesthetics____ Ibuprofen____Epinephrine____
Other (Please list)

_____

Y___N___Do you have any food allergies? (Strawberries / bananas / kiwi / nuts / lactose milk / other)

Please add any additional information you would like the doctor to know. _____

_____

_____

By signing below I verify that all information given above is true and correct to the best of my knowledge. Your signature is also necessary for us to process all insurance claims and to release information to insurance companies, schools, pharmacy, and other medical/dental providers for as long as you are a patient of our practice.

PATIENT SIGNATURE (PARENT OR GUARDIAN IF MINOR)

_____ **DATE** _____

FOR OFFICE USE ONLY: MEDICAL HISTORY REVIEWS/UPDATES