

Welcome

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain optimal oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

About You

Today's Date: _____ E-mail Address: _____

Name: _____ I prefer to be called: _____ Male Female
Last First Mi Mr Mrs Ms Dr

Birthdate: _____ Age: _____ Social Security #: _____ Single Married Divorced Widowed Separated

Home Address: _____
Street City State Zip

Home Phone #: _____ Cell #: _____ Work Phone #: _____ Ext: _____ Driver License #: _____

Where & when are best times to reach you? _____ Whom may we Thank for referring you? _____

Other family members seen by us: _____

Employer: _____ How long there? _____ Occupation: _____

Employer's Address: _____
Street City State Zip

Neighbor or Relative not living with you

His / Her Name: _____ Relation: _____ Work Phone #: _____ Home Phone #: _____

Address: _____
Street City State Zip

Person Responsible for Account if other than yourself

Name: _____ Relation: _____ Home Phone #: _____ Social Security #: _____

Employer: _____ Work Phone #: _____ Ext: _____ Drivers License #: _____

Billing Address: _____
Street City State Zip

Spouse Information

His / Her Name: _____ Birthdate: _____ Social Security #: _____

Employer: _____ Work Phone #: _____ Ext: _____ Drivers License #: _____

Insurance Information

Primary Insurance Dental Coverage? Yes No Medical Coverage? Yes No Orthodontic Coverage? Yes No

Insurance Co. Name: _____ Phone #: _____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street/PO Box City State Zip

Insured's Name: _____ Insured's Social Security #: _____ Insured's Birthdate: _____ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street/PO Box City State Zip

Secondary Insurance Dental Coverage? Yes No Medical Coverage? Yes No Orthodontic Coverage? Yes No

Insurance Co. Name: _____ Phone #: _____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street/PO Box City State Zip

Insured's Name: _____ Insured's Social Security #: _____ Insured's Birthdate: _____ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street/PO Box City State Zip

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Dental History

Why have you come to the dentist today?

- Are you currently in pain? Yes No
- Do you require antibiotics before dental treatment? Yes No
- Have you experienced problems associated with any previous dental work? Yes No
- Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? Yes No
- Your current dental health is Good Fair Poor
- Do you floss daily? Yes No Brush daily? Yes No
- Type of bristles on your toothbrush? Hard Medium Soft
- How long do you use a toothbrush before replacing it? _____
- Do you use anything in addition to your brush and floss? Yes No
- If yes, what? _____
- Would you like fresher breath? Yes No Whiter teeth? Yes No

- Do your gums ever bleed? Yes No Ever Itch? Yes No
- Have you ever had periodontal disease? Yes No
- Do you have mobility in your teeth? Yes No
- Are your teeth sensitive to heat, cold, or anything else? _____
- Do you still have wisdom teeth? Yes No
- If yes, why? _____
- When were you last seen by a dentist? _____
- Why did you leave your previous dentist? _____
- What did you like most & least about any dentist you have seen? _____

- Are you happy with the way your smile looks?** Yes No
- If not, what would you change? _____

Medical History

- Do you have a personal physician? Yes No
- Physician's Name: _____
- Address: _____
Street City State Zip
- Phone #: _____ Date of last visit: _____
- Your current physical health is:** Good Fair Poor
- Are you currently under the care of a physician? Yes No
- Please explain: _____
- Do you smoke or use tobacco in any other form? Yes No
- Have you ever taken Fosamax, or any other Bisphosphonate? Yes No
- Have you ever taken Phen-Fen? Also known as Redux or Pondimin. Yes No

- Are you allergic to any of the following?**
- | | | |
|------------------------|----------------------|------------------|
| Y N Aspirin | Y N Erythromycin | Y N Sedatives |
| Y N Barbiturates | Y N Jewelry / Metals | Y N Sulfa Drugs |
| Y N Codeine | Y N Latex | Y N Tetracycline |
| Y N Dental Anesthetics | Y N Penicillin | Y N Other |

Please list additional drugs/materials that cause allergic reactions: _____

- For Women:** Are you taking birth control pills? Yes No
- Are you pregnant? Unsure Yes No
- Week #: _____ Are you nursing? Yes No

Are you taking any of the following?

- | | | | | |
|--------------------|-------------------------|--------------------------------|----------------------------|------------------------|
| Y N Acetaminophen | Y N Aspirin | Y N Cold Remedies | Y N Insulin/Diabetes Drugs | Y N Steroids/Cortisone |
| Y N Antibiotics | Y N Blood Pressure Meds | Y N Digitalis/Heart Medication | Y N Nitroglycerin | Y N Thyroid Medicine |
| Y N Antihistamines | Y N Blood Thinners | | Y N Recreational Drugs | Y N Tranquilizers |

Are you taking any prescription, over-the-counter drugs, herbal remedies, vitamins or minerals not listed above? Yes No If yes, please list each one: _____

Do you or have you experienced the following?

- | | | | | |
|-----------------------------|-----------------------------|---------------------------------|----------------------------------|-------------------------|
| Y N Abnormal Bleeding | Y N Colitis | Y N Headaches | Y N Liver Disease | Y N Seizures |
| Y N Alcohol Abuse | Y N Congenital Heart Defect | Y N Heart Attack | Y N Low Blood Pressure | Y N Shingles |
| Y N Anemia | Y N Diabetes | Y N Heart Murmur | Y N Lupus | Y N Sickle Cell Disease |
| Y N Arthritis | Y N Difficulty Breathing | Y N Heart Surgery | Y N Mitral Valve Prolapse | Y N Sinus Problems |
| Y N Artificial Bones/Joints | Y N Drug Abuse | Y N Hemophilia | Y N Osteoporosis/Paget's Disease | Y N Steroid Therapy |
| Y N Artificial Valves | Y N Emphysema | Y N Hepatitis | Y N Pacemaker | Y N Stroke |
| Y N Asthma | Y N Epilepsy | Y N Herpes | Y N Persistent Cough | Y N Thyroid Problems |
| Y N Blood Transfusion | Y N Fainting Spells | Y N High Blood Pressure | Y N Psychiatric Problems | Y N Tonsillitis |
| Y N Cancer | Y N Fever Blisters | Y N HIV+/AIDS | Y N Radiation Treatment | Y N Tuberculosis (TB) |
| Y N Chemotherapy | Y N Glaucoma | Y N Hospitalized for any reason | Y N Rheumatic Fever | Y N Ulcers |
| Y N Chicken Pox | Y N Hay Fever | Y N Kidney Problems | Y N Scarlet Fever | Y N Venereal Disease |

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

Authorization

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need. My method of payment will be _____.

Signature _____ Date _____

PAYMENT IS DUE AT TIME OF SERVICE

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I certify that I am covered by _____ Insurance Co. and I assign to American Dental Offices, PLLC all insurance benefits., otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature _____

Date _____