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friendly family dentistry

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Welcome

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

1. About You

Today's Date: / /

E-mail Address:

Last Name:

First Name: M.I.:

I prefer to be called: [ ] Male [ ] Female

Birthdate: / / Age: SS#:

Home Address: APT/Condo #:

City: State: Zip:

[ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Separated

Home #:

Cell #:

Work #: Ext:

Direct Line #:

Employer:

Employer's Address:

How long there? Occupation:

Where & when are the best times to reach you?

Whom may we Thank for referring you?

Other family members seen by us:

Previous / Present Dentist (please circle):

Date of Last Visit:

2. Spouse Information

His / Her Name:

Employer:

Work #: Ext:

SS#:

Birthdate: / /

Driver's License #:

Person Responsible for Account:

Work #: Ext:

Home #:

Billing Address: APT/Condo #:

City: State: Zip:

Relation:

SS#:

Employer:

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3. Insurance Coverage

Primary

Dental Coverage: [ ] Yes [ ] No

Insurance Co. Name:

Insurance Company Address:

City: State: Zip:

Insurance Co. Phone #:

Group # (Plan, Local, or Policy #):

Insured's Name:

Relation:

Insured's Birthdate: / /

Insured's ID #:

Insured's Employer:

Secondary

Dental Coverage: [ ] Yes [ ] No

Insurance Co. Name:

Insurance Company Address:

City: State: Zip:

Insurance Co. Phone #:

Group # (Plan, Local, or Policy #):

Insured's Name:

Relation:

Insured's Birthdate: / /

Insured's ID #:

Insured's Employer:

In the event of an emergency, is there someone who lives near you that we should contact?

His / Her Name:

Relation:

Work #: Ext:

4. Medical History

Do you have a personal physician? [ ] Yes [ ] No

Physician's Name:

Phone #:

Date of Last Visit:

Are you currently under the care of a physician? [ ] Yes [ ] No

Please Explain:

Your current physical health is: [ ] Good [ ] Fair [ ] Poor

Are you taking any prescription/over-the-counter or herbal supplement drugs?

[ ] Yes [ ] No

Please list each one:

Have you ever taken Fosamax, or any other bisphosphonate? [ ] Yes [ ] No

Have you been told that you snore or hold your breath while sleeping or wake up gasping for air? [ ] Yes [ ] No

For Women: Are you using a prescribed method of birth control? [ ] Yes [ ] No

Are you pregnant? [ ] Yes [ ] No

Week #:

Are you Nursing? [ ] Yes [ ] No

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4. Medical History cont'd

Have you ever had any of the following diseases or medical problems?

Y	N	Abnormal Bleeding	Y	N	Hepatitis
Y	N	Alcohol / Drug Abuse	Y	N	Herpes/Fever Blisters
Y	N	Anemia	Y	N	High Blood Pressure
Y	N	Arthritis	Y	N	HIV+/AIDS
Y	N	Artificial Joints/Bones/Valves	Y	N	Hospitalized for Any Reason
Y	N	Asthma	Y	N	Kidney Problems
Y	N	Blood Transfusion	Y	N	Liver Disease
Y	N	Cancer/Chemotherapy	Y	N	Low Blood Pressure
Y	N	Colitis	Y	N	Mitral Valve Prolapse
Y	N	Congenital Heart Defect	Y	N	Pacemaker
Y	N	Diabetes	Y	N	Psychiatric Treatment
Y	N	Difficulty Breathing	Y	N	Radiation Treatment
Y	N	Emphysema	Y	N	Rheumatic/Scarlet Fever
Y	N	Epilepsy	Y	N	Seizures
Y	N	Fainting Spells	Y	N	Shingles
Y	N	Frequent Headaches	Y	N	Sickle Cell Disease/Traits
Y	N	Glaucoma	Y	N	Sinus Problems
Y	N	Hay Fever	Y	N	Stroke
Y	N	Heart Attack	Y	N	Thyroid Problems
Y	N	Heart Murmur	Y	N	Tuberculosis (TB)
Y	N	Heart Surgery	Y	N	Ulcers
Y	N	Hemophilia	Y	N	Venereal Disease

Please list any serious medical condition(s) that you have ever had:

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Latex
Y	N	Codeine	Y	N	Metals
Y	N	Dental Anesthetics	Y	N	Penicillin
Y	N	Erythromycin	Y	N	Tetracycline
Y	N	Jewelry			

Please list any other drugs/materials that you are allergic to:

5. Dental History

Why have you come to the dentist today?

Do you require antibiotics before dental treatment? [ ] Yes [ ] No

Are you currently in pain? [ ] Yes [ ] No

Do your gums ever bleed? [ ] Yes [ ] No

Have you ever had a serious/difficult problem associated with 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 like your smile? [ ] Yes [ ] No

Would you like whiter teeth? [ ] Yes [ ] No

Would you like fresher breath? [ ] Yes [ ] No

How many time a week do you floss? ...a day do you brush?

Type of bristles? [ ] Soft [ ] Medium [ ] Hard

Do you smoke or use tobacco in any other form? [ ] Yes [ ] No

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Agreement

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information 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 any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature Date

Payment is due in full at the time of treatment unless prior arrangements have been approved.

Insurance

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

Signature Date

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

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein. **Initials:** **Date:**

Doctor's Comments:

Medical History Update

1. Date: Comments: Signature:
2. Date: Comments: Signature:
3. Date: Comments: Signature:

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Before the Examination Conversation

Get to Know the Patient

1. Tell me about your family:

   Tell me about your line of work:

   Tell me about what you do in your spare time:

2. In addition to information you've learned so far, how can we help you today?

3. What type of dental treatment have you had in the past?

   Why was it done?

4. Have you ever had a negative experience in a dental ofice?

5. Have you ever had gum problems or gum surgery?

   Do your gums bleed when you brush your teeth?

6. Have you ever lost any teeth?

   Have you replaced the missing teeth with anything?

7. What improvements would you make in your teeth if you could change anything?

8. On a scale of 1 - 10, with 10 being extremely important, how important is it for you to keep all of your teeth for a lifetime?

9. Out of curiosity, what do you look for in a dentist and his/her team?

10. Is there anything that would stand in your way of getting the proper dentistry you need?

11. Do you have any time constraints for the completion of your dentistry?

12. Do you have any questions?