In order for us to care for you to the best of our ability please fill out this form completely. If you have any questions about any part of this form please ask for assistance. Please be assured that all of this information will be kept in the strictest confidence. Thank you and welcome to our office.

PLEASE TELL US ABOUT YOURSELF

Today's Date: _____

Name: Mr Mrs Ms Dr _____
Last First MI

❍Single ❍ Married ❍Divorced ❍Widowed ❍Separated

I prefer to be called: _____

S.S. # _____ Birthdate: / / Age: _____

email address _____

Home Address: _____ Apt # _____

City _____ State _____ Zip _____

Phone #: Home ( ) _____ Work ( ) _____

Where & when are the best times to reach you ? _____

Employer: _____

Employer Address: _____
City State Zip

How long there? _____ Occupation : _____

Who may we thank for referring you? _____

Other family members seen by us: _____

DENTAL INSURANCE

1. Person Responsible for this account: _____ Relationship _____
(If patient is responsible, you may skip questions #2 & 3)
2. Telephone #: Home: ( ) _____ Work: ( ) _____
3. Address: _____

Primary Dental Insurance

4. Insurance Company Name: aetna Group # (Plan, Local or Policy #) _____
5. Insurance Company Address: _____
(Please complete questions 6-9 only if the patient is not the insured)
6. Insured's Name: _____ Relationship: _____
7. Insured's Birthdate: / / Insured's SS#: _____ Insured's Phone # ( ) _____
8. Insured's Employer (name and address): _____
9. Insured's Employer Telephone #: ( ) _____
10. Are you covered by a secondary Dental Insurance? ❍Yes ❍No

Please complete the back of this form

MEDICAL HISTORY

Do you have a personal physician? ○Yes ○No
Physician's Name: _____ Telephone: ( ) _____
Physician's Address: _____ Date of last visit: _____
Your current physical health is: ○Good ○Fair ○Poor. Are you currently under the care of a physician? ○Yes ○No
If Yes, please explain _____
Do you smoke? ○Yes ○No Are you taking any prescription / over the counter drugs? ○Yes ○No
If Yes, please list each one _____
For Women: Are you pregnant? ○Yes ○No Week # _____ Are you nursing? ○Yes ○No
Are you taking birth control pills? ○Yes ○No (The use of antibiotics may reduce the effectiveness of birth control drugs)

Have you ever had any of the following diseases or medical problems?(Please check Yes(Y) or No(N) for each)

Y	N		Y	N		Y	N	
○	○	Heart Attack / Stroke	○	○	Cancer / Chemotherapy	○	○	Heart Murmur
○	○	Rheumatic Fever / Shingles	○	○	HIV+ / AIDS	○	○	Tonsilitis
○	○	Heart Surgery / Pacemaker	○	○	Mitral Valve Prolapse / Aritificial Valves	○	○	Kidney Problems
○	○	Artificial Bones / Joints	○	○	Frequent Urination or Thirst	○	○	Sinus Problems
○	○	High / Low Blood Pressure	○	○	Fever Blisters	○	○	Phychiatric Problems
○	○	Severe / Frequent Headaches	○	○	Epilepsy / Seizures / Fainting Spells	○	○	Drug / Alcohol Abuse
○	○	Diabetes / Tuberculosis (TB)	○	○	Venereal Disease	○	○	Ulcers / Colitis
○	○	Congenital Heart Defect	○	○	Anemia / Radiation Therapy	○	○	Asthma / Arthritis
○	○	Difficulty Breathing	○	○	Hospitalized for Any Reason	○	○	Hepatitis
○	○	Corrective Eye Lenses	○	○	Emphsema / Glaucoma	○	○	Blood Transfusion

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

Are you allergic to any of the following drugs?(Please check Yes(Y) or No(N) for each)

Y	N		Y	N		Y	N		Y	N	
○	○	Penicillin / Sulfur Drugs	○	○	Erythromycin	○	○	Tetracycline	○	○	Aspirin
○	○	Latex	○	○	Dental Anesthetics	○	○	Codeine	○	○	Other

Please list any other drugs that you are allergic to:_____
In the event of an emergency, is there someone who lives near you that we should contact?
Name: _____ **Relationship:** _____
Telephone #: Home ( ) _____ **Work ( )** _____

DENTAL HISTORY

Why have you come to the dentist today? _____
Have you ever had a reaction to any dental treatment? _____
Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ)? ○Yes ○No
Do you favor one side when you eat? ○Yes ○No Do your gums bleed? ○Yes ○No
Do you grind your teeth or bite your cheeks? ○Yes ○No
Have you ever had: Facial or oral surgery ○Yes ○No, Periodontal Surgey? ○Yes ○No, Orthodontics ○Yes ○No
When was the last time you visited a dental office? _____
Who was you last dentist? _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that 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 with my informed consent that I may need during diagnosis and treatment. I furthermore agree to be responsible for payment of those services rendered or for any collection thereof.

_____
Signature Date

FOR OFFICE USE ONLY

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

Date _____ Initials _____	Date _____ Initials _____	Date _____ Initials _____
Date _____ Initials _____	Date _____ Initials _____	Date _____ Initials _____