Welcome

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

(Please Print)

Date: _____ SS#_____

Last Name: _____ First Name:_____MI_____

I prefer to be called: _____ Sex: M F Age:_____ Birth date: __

Single_____ Married_____ Widowed_____ Separated_____ Divorced ___

Address: _____ City_____

State_____ Zip _____ Email: _____

Home#: _____ Work#: _____

Cell#:_____ Fax# _____

Employer: _____ Occupation: _____

Whom may we thank for referring you? _____

* *

YOUR APPOINTMENT TIME IS RESERVED EXCLUSIVELY FOR YOU. THERE WILL BE A $50.00 FEE FOR ANY APPOINTMENTS MISSED OR CANCELLED WITH LESS THAN 24 HOURS NOTICE

* *

Will you be seeking reimbursement from your dental insurance company?_____
If so, we will provide claim forms with treatment information, as well as narratives and/or x-rays that may be needed for you to submit a claim to your insurance company for reimbursement.

Person to notify in case of emergency:

Name: _____

Phone: _____

Name(s) of former dentists: _____

Are you currently under the care of a health care practitioner? _____

Name:_____ Phone#:_____

(Please complete back of form also)

Please list all prescriptions and/or over the counter medications you are taking: _____

_____

Do you smoke:_____

For Women: Pregnant?_____ Nursing_____ Do you take birth control pills: _____

* *

_____ **I HAVE A HISTORY OF BEING HARD TO NUMB FOR DENTAL TREATMENT.**

Please check any of the following diseases or medical problems you have had:

_____ Abnormal bleeding
_____ AIDS
_____ Alcohol Abuse (past) (present)
_____ Anemia
_____ Artificial heart valves or joints
_____ Asthma
_____ Arthritis
_____ Breathing Difficulty
_____ Blood transfusion
_____ Cancer/Chemotherapy
_____ Cold Sores/ Fever Blisters
_____ Congenital heart defect
_____ Diabetes
_____ Drug Abuse (past) (present)
_____ Emphysema
_____ Epilepsy
_____ Fibromyalgia
_____ Fossamox use, or other bisphosphonate med.
_____ Headaches
_____ Heart Attack
_____ Heart Murmur
_____ Heart Surgery
_____ Heart Fibrillator/Pacemaker
_____ Hemophilia
_____ Hepatitis
_____ High Blood Pressure
_____ HIV Positive
_____ Kidney Problems
_____ Low Blood Pressure
_____ Mercury Toxicity
_____ Mitral Valve Prolapse
_____ Multi-chemical Sensitivity
_____ Pacemaker / Fibrillator
_____ Phen Fen Use
_____ Psychiatric Problems
_____ Rheumatic Fever
_____ Seizures
_____ Sexually-transmitted Disease
_____ Sinus Problems
_____ Stroke
_____ Tuberculosis
_____ Thyroid Disease

Please list any other serious condition:
_____
_____

Please check any of the following that you are allergic to:

_____Penicillin _____ Erythromycin _____ Tetracycline _____ Codeine
_____Aspirin _____ Latex _____ Dental anesthetics _____ Other

Are there any other drugs that you are allergic to?_____

* *

I understand that the fee estimate listed on my treatment plan can be extended for a period of six months from the date of my initial examination. In consideration of the professional services rendered to me at my request, by the doctor and /or his staff, I agree to pay said doctor for services at the time services are rendered.

I declare that the information 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 that it is my responsibility to inform this office of any changes in my medical status.

_____ _____

SIGNATURE *DATE*