

Our goal is to help you achieve and maintain optimum oral health for a lifetime. So that we may best serve you, please complete these forms before your initial appointment with our office. We appreciate the confidence you've placed in us by selecting our team of dental professionals. We will continue to warrant that trust as we serve your dental needs

Personal Profile

Date ____/____/____

First Name _____ Middle Initial _____ Last Name _____

I like to be called _____ Male Female

Date of Birth ____/____/____ Age: ____ Social Security # ____-____-____ Driver's License# _____

Address _____ City _____ State _____ Zip _____

Home Phone: (____) _____ Work Phone:(____) _____ Ext _____

Pager _____ E-mail _____ Cell Phone _____ Fax Phone _____

What number would you like us to call you on regarding your appointments? _____

Name of Employer; _____ Occupation: _____

Address _____ City _____ State _____ Zip _____

Who may we thank for referring you to our practice?

Previous dentists name: _____

Last seen by your previous dentist? _____ Treatment rendered: _____

Would you like us to contact your previous dentist for applicable records? No Yes

Account information

Responsible party's name: _____

Address _____ City _____ State _____ Zip _____

Home Phone: (____) _____ Work Phone:(____) _____ Ext _____

Social Security # ____-____-____ Date of Birth ____/____/____ Driver's License# _____

Insurance information - Primary

Insurance Company Name: _____

Address _____ City _____ State _____ Zip _____

Insured's First name _____ Middle Initial _____ Last Name _____

Social Security # ____-____-____ Date of Birth ____/____/____ Driver's License# _____

Insurance information - Secondary

Insurance Company Name: _____

Address _____ City _____ State _____ Zip _____

Insured's First name _____ Middle Initial _____ Last Name _____

Social Security # ____-____-____ Date of Birth ____/____/____ Driver's License# _____

Who should we contact in the unlikely event of an emergency:

Name: _____ Relationship to patient _____

Home Phone:(____) _____ Work Phone:(____) _____ Ext _____

E-mail: _____ Cell phone (optional) _____

PATIENT REGISTRATION INFORMATION

Medical History Form

Patient's Last Name _____ Middle Initial _____ First Name _____

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

For what reason: _____

When was your last physical exam? _____

Physician's Name _____

Address _____ Phone _____ Last Time seen _____

Have you ever been hospitalized? No Yes

If yes, please explain _____

Are you taking any prescription medication? No Yes

If yes, please explain _____

Are you taking any over the counter medication? No Yes

If yes, please explain _____

Do you have any allergies? No Yes

If yes, please explain _____

Are you allergic to any medications or substances? No Yes

If yes, please explain _____

Do you have any problems with antibiotics or anesthetics? No Yes

If yes, please explain _____

Do you take appetite suppressants? No Yes Name of product: _____

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

- | | | | | | |
|-----------------------------|------------------------------|-------------------------|-----------------------------|------------------------------|-------------------------|
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Heart Attack/Stroke | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Epilepsy |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Cancer/Chemotherapy | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Seizures |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Heart Murmur | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Fainting |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Rheumatic Fever | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Diabetes |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | HIV/AIDS | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Tuberculosis |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Hepatitis A | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Hemophilia |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Hepatitis B | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Blood Transfusion |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Hepatitis C | <input type="checkbox"/> No | <input type="checkbox"/> Yes | High Blood Pressure |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Hepatitis D | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Low Blood Pressure |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Anemia | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Radiation Treatment |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Mitral Valve Prolapse | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Kidney Problems |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Artificial Bones/Joints | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Artificial Valves |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Sinus Problems | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Severe Headaches |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Asthma | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Frequent Headaches |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Difficulty Breathing | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Emphysema |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Venereal Disease | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Shingles |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Herpes Type I | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Herpes Type II |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Heart Surgery | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Pace Maker |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Psychiatric Problems | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Glaucoma |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Do You Smoke? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Do You Consume Alcohol? |

Are You Allergic To Any of The Following?

- | | | | | | |
|-----------------------------|------------------------------|--------------------------|-----------------------------|------------------------------|-----------------------|
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Penicillin | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Codeine |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Aspirin | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Tetracycline |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Erythromycin | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Germicides/Pesticides |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Latex/or Rubber Products | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Other _____ |

For Women Only:

- | | | | | | |
|-----------------------------|------------------------------|----------------------------|-----------------------------|------------------------------|-------------------------------|
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Taking Birth Control Pills | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Pregnant/No. of Months: _____ |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Nursing? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Hormone Therapy |

Signature _____ Date _____

Smile Survey

Our office is conducting a survey of our patients. If you would kindly answer a few questions below, it would be greatly appreciated. 😊

How do you feel about your smile?

If you could change anything about your smile, what would it be? (If you had a magic wand!)

Is there anything that would keep you from improving your smile? If so, please explain.

Are you familiar with how today's dentistry can enhance your smile? Yes / No

Would you like to learn more about how you can improve your smile? Yes / No

Your name: _____

Thank You! 😊
