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OFFICE USE ONLY

M G B

ACCT. #

Welcome,

Our goal is to help you reach and maintain maximum oral health, and a smile you can be proud of. Please fill this form out completely — front and back. The better we communicate, the better we can care for you.

PLEASE PRINT **DATE OF BIRTH** ______________ **TODAY'S DATE** ______________

EMAIL ______________ **PHONE (H)** ______________ **(BUS)** ______________

WE RESERVE THE RIGHT TO CALL YOUR CELL PHONE TO DISCUSS YOUR ACCOUNT. **CELL PHONE** ______________

DRIVER'S LICENSE NO. ______________

NAME ______________ (LAST / FIRST / MIDDLE) PREFERRED NAME ______________ MALE ______ FEMALE ______

ADDRESS ______________ (RESIDENCE & BOX IF APPLICABLE / CITY / STATE / ZIP)

EMPLOYER ______________ STUDENT ONLY SCHOOL/GRADE ______________

JOB TITLE/POSITION ______________ SOCIAL SECURITY # ______________

SINGLE ( ) MARRIED ( ) SEPARATED ( ) DIVORCED ( ) WIDOW OR WIDOWER ( )

SPOUSE NAME ______________ DATE OF BIRTH ______________ PATIENT HERE? YES ( ) NO ( )

IF MINOR, PARENT(S) NAME(S) ______________ PATIENTS HERE? YES ( ) NO ( )

CHILDREN'S NAMES & AGES ______________

______________ PATIENTS HERE? YES ( ) NO ( )

PLEASE LIST OTHER RELATIVES THAT ARE PATIENTS IN THIS OFFICE AND THEIR RELATIONSHIP TO YOU ______________

____

REFERRED BY: ______________

PERSON RESPONSIBLE FOR ACCOUNT — IF SAME AS ABOVE, PLEASE CHECK ( )

NAME ______________ RELATIONSHIP TO PATIENT ______________

ADDRESS ______________ (RESIDENCE & BOX IF APPLICABLE / CITY / STATE / ZIP)

EMPLOYER & POSITION ______________ SS # ______________

HOME PHONE ______________ BUSINESS PHONE ______________

INSURANCE COVERAGE OF PATIENT:

DENTAL INSURANCE CO. ______________ ID # ______________

GROUP # ______________ TELEPHONE # ______________

ADDRESS ______________

IF SECONDARY COVERAGE ALSO:

DENTAL INSURANCE CO. ______________ ID # ______________

GROUP # ______________ TELEPHONE # ______________

ADDRESS ______________

PLEASE COMPLETE BACK SIDE

MEDICAL HISTORY

Your current health is: Good ______ Fair ______ Poor ______

Personal Physician: Yes ______ No ______ Name ______

Approximate date of last medical examination ______

May we request your health record, if necessary? ______

Are you presently taking any medications including herbal supplements or **ASPIRIN**? Yes ______ No ______

If yes, please list: ______

Have you had any medical problems in the last 5 years? Yes ______ No ______

Please explain: ______

Are you allergic or sensitive to any medications or materials (including anesthetic, latex, antibiotics, acrylics, etc.)? Yes ______ No ______

If yes, please list: ______

Do you have or have you ever had *(circle yes or no)*:

1. Rheumatic Fever .... Yes No
2. Heart Murmur/Heart Malformations .... Yes No
3. Mitral Valve Prolapse .... Yes No
4. Heart Surgery/Pacemaker/Artificial Valve .... Yes No
5. Hepatitis or Jaundice .... Yes No
6. Anemia .... Yes No
7. High/Low Blood Pressure .... Yes No
8. Severe Headaches .... Yes No
9. Epilepsy/Seizures/Fainting Spells .... Yes No
10. Drug/Alcohol Abuse .... Yes No
11. Bleeding Disorder/Abnormal Bleeding .... Yes No
12. Breathing Problems .... Yes No
13. Cancer/Chemo .... Yes No
14. Possible Exposure to AIDS Virus .... Yes No
15. HIV Positive .... Yes No
16. Kidney/Liver PR .... Yes No
17. Sinus Problems .... Yes No
18. History - Stroke .... Yes No
19. Shunt, hip or knee replacement or any medical condition you may need antibiotics before dental treatment. .... Yes No
20. Alzheimers or Dementia .... Yes No
21. Have you taken any meds. for osteoporosis (i.e. Fosamax) .... Yes No
22. Fever Blisters .... Yes No
23. Diabetes .... Yes No
24. Tuberculosis .... Yes No
25. Sickle Cell .... Yes No
26. Stomach Problems .... Yes No
27. Chest Pain on Exertion .... Yes No
28. Depression .... Yes No
29. Panic Disorder .... Yes No
30. For Women: Are you pregnant or think you might be? .... Yes No
31. Do you have any other medical conditions we should be aware of? .... Yes No
    If yes, please explain ______

Do you use tobacco products? .... Yes No

If yes, what type and how much ______

DENTAL HISTORY

Reason for dental visit today ______

Approximate date of last dental visit ______

1. Do you have any pain associated with your jaw joints or the muscles in the sides of your face? .... Yes No
2. Do you clench or grind your teeth? .... Yes No
3. Do you like your smile? .... Yes No
4. Do your gums bleed? .... Yes No
5. Do you consider yourself to have mouth odor problems? .... Yes No
6. Would you be interested in bleaching your teeth? .... Yes No
7. Do you eat or drink any sugared items on a fairly consistent basis? (soft drinks, chewing gum, cough drops, mints, sugared tea, candy, etc.) .... Yes No
   If yes, what and how much? ______
8. Is there anything else about your mouth, teeth, or reaction to dentistry that you would like us to know about? .... Yes No
   If yes, please explain ______

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the dentist and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay promptly any deductible amount, co-insurance, or any other balance not paid for by your insurance company. Payment is due when service is rendered for any amount estimated not to be covered by dental insurance. All insurance payments must be assigned to our office if payment for services is based on a percentage of estimated insurance coverage. Prior financial arrangements must be approved if payment is different from the above.

I understand that the information that I have given today is correct to the best of my knowledge and that it is my responsibility to inform this office of any changes in my medical status.

______

SIGNATURE (IF MINOR, SIGNATURE OF PARENT OR GUARDIAN) DATE

As required by the Privacy Regulations, I hereby acknowledge that I have received a copy of this office's Notice of Privacy Practices.

______

Thank you for filling out this form completely. It will help us to serve your dental needs more effectively. If you have any questions at any time, please ask us. We are happy to help you!

**OUR OFFICE IS COMMITTED TO MEETING OR EXCEEDING THE STANDARDS OF INFECTION CONTROL MANDATED BY OSHA, THE CDC AND THE ADA.