WELCOME

Please fill this form completely, it is important for your care.

ABOUT YOU

Today's Date:______________ ( ) Married ( ) Single ( ) Partnered ( ) Divorced ( ) Widowed

Name:________________________________ ( ) M ( ) F Birthdate:___/___/___ Age:____

Home Address:____

H# ( )_________________C# ( )___________________W# ( )________________

SS#______/____/______ email address:____

Drivers license #______________________________________ (State)

Whom may we thank for referring you:____

Employer:_______________________________ Occupation:__________________________

Address;____

In the event of an emergency, whom should we contact?

His/Her Name:_______________________ Relation:_________ W# ( )_______________

H# ( )___________________C#_________________Address:______________________

SPOUSE INFORMATION

HIS/HER NAME:_________________________________ BIRTHDATE:____/_____/____

SS#____________________________ EMPLOYER:_______________________________

Drivers license#____________________________ (State) W#:___________________

Person Responsible for Account, if other then yourself

Name:_________________________ Relation:____________ SS#_____/____/_____

Employer:_________________________________ W# ( )______________________

Drivers license#___________________________ (State) H#______________________

Billing Address:____

INSURANCE INFORMATION

PRIMARY INSURANCE

Ins. Co. Name:______________________________ Phone# (   )________________

Group #___________

Address:____

Insured's Name: ____ Relation:__________

SS#_____/____/______

Insured's Birthdate: ____/___/___

Insured's Employer :___________________________

Employer's Address: ____

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SECONDARY INSURANCE:

Ins. Co. Name:____________________________ Phone # (   )________________

Group #___________

Address:____

Insured's Name: _______________________________________ Relation:__________

SS#_____/____/______

Insured's Birthdate: ____/___/___

Insured's Employer :___________________________

Employer's Address: ____

HISTORY

Why have you come to the dentist today?____

Are you currently in pain? Y N

Do you require antibiotics before any dental work? Y N

For what?____

Have you experienced problems associated with any previous dental work? Y N

Do you now or have you experienced pain/discomfort in your jaw (TMJ/TMD)? Y N

You current dental health is: ( ) Good ( ) Fair ( ) Poor

Do you floss daily? Y N Do you Brush Daily? Y N Have you ever had periodontal disease Y N

How often do you replace your toothbrush? __________ Do your gums bleed? Y N

Would you like fresher breath? Y N Whiter teeth? Y N Do you have mobility in your teeth? Y N

Are you happy with the way your smile looks? Y N If not, what would you change?______________

____

Do you have a personal physician? Y N Physicians Name:_____________________________

Address: ____

Phone # ( ) _________________ date of last visit: ____________________________

Are you currently under the care of a physician? Y N

Please explain: ____

Do you smoke or use tobacco in any form? Y N

Are you allergic to any of the following: please circle

Aspirin	Erythromycin	Sedatives	Barbiturates
Jewelry/Metals	Sulfa Drugs	Codeine	Latex
Tetracycline	Dental Anesthetics	Penicillin	

Please list additional drugs/materials that cause allergic reactions:_________________________

____

Are you taking any of the following:

Acetaminophen	Blood Pressure Medication	Recreational Drugs	Aspirin	List Additional medications below:
Antibiotics	Cold Remedies	Steriods/ Cortisone	Antihistamines	______________________
Thyroid Medicine	Insulin/ Diabetes Drugs	Digitalis/Heart Medication		______________________
Blood Thinners	Nitroglycerine	Tranquilizers		______________________

Have you ever taken Phe-Fen (Redux or Pondimin)? Y N

Have you ever taken Fosamax or any other Bisphosonate? Y N

Are you currently taking any prescription, over-the-counter drugs, herbal remedies, vitamins or minerals not listed above? Y N If Yes please list:_______________________________________

____

WOMEN: Are you taking birth control pills? Y N

Are you pregnant? Y N Unsure Week# _________ Are you nursing? Y N

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

Abnormal bleeding	Y	N	Headaches	Y	N	Liver Disease	Y	N	Seizures	Y	N
Alcohol Abuse	Y	N	Heart Attack Y N When?_______			Low Blood Pressure	Y	N	Shingles	Y	N
Anemia	Y	N	Diabetes	Y	N	Heart Murmur	Y	N	Lupus	Y	N
Arthritis	Y	N	Heart Surgery	Y	N	Mitral Valve Prolapse	Y	N	Sinus Problems	Y	N
Asthma	Y	N	Drug Abuse	Y	N	Hemophilia	Y	N	Osteoporosis	Y	N
Cancer	Y	N	Emphysema	Y	N	Epilepsy	Y	N	Hepatitis	Y	N
Chemotherapy	Y	N	Fainting spells	Y	N	Herpes	Y	N	Thyroid Problems	Y	N
Blood Transfusion	Y	N	Fever blisters	Y	N	HIV/AIDS	Y	N	Persistent Cough	Y	N
Chicken Pox	Y	N	Glaucoma	Y	N	Kidney Problems	Y	N	High Blood Pressure	Y	N
Hay Fever	Y	N	Radiation Treatment	Y	N	Rheumatic Fever	Y	N	Tuberculosis	Y	N
Scarlet Fever	Y	N	Venereal Disease	Y	N	Artificial Valves	Y	N	Difficulty Breathing	Y	N
Ulcers	Y	N	Colitis	Y	N	Tonsillitis	Y	N	Congenital Heart Disease	Y	N
Pacemaker	Y	N	Stroke	Y	N	Steroid Therapy	Y	N	Sickle Cell Disease	Y	N

Do you snore? Y N Do you have Sleep Apnea? Y N Do you use: (circle one) C-PAP Oral appliance

Do you have any artificial Joints?______________________ When placed?________________________

Have you been Hospitalized for any reason in the past five years? For what?________________________
When? _________________________

AUTHORIZATIONS

I affirm that the information I have given is correct to the best of my knowledge. It 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 the necessary dental services I may need.

SIGNATURE:____DATE: ________________

I certify that I am covered by __________________________________Insurance company and I assign directly to Dr. Small all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

SIGNATURE:____DATE: ___________________

Thank you