Welcome

ABOUT YOU

Name_____
Address_____
City_____ State_____ Zip_____
Home Phone_____ Other Phone_____
Date of Birth_____ Age_____
Social Security #_____
Employer_____

ACCOUNT INFORMATION

Will you be added to an existing account?_____
Person Responsible for Account
Name_____
Address_____
City_____ State_____ Zip_____
Home Phone_____ Other Phone_____
Employer _____

How did you find out about our office? _____

Insurance Information

Primary Dental Insurance

Subscriber_____
Subscriber Date of Birth_____
Social Security #_____
Relationship: **Self Spouse Child Other**
Subscriber's Employer_____
Insurance Company Name_____
Address_____
City_____ State_____ Zip_____
Phone Number_____

Secondary Dental Insurance

Subscriber_____
Subscriber Date of Birth_____
Social Security #_____
Relationship: **Self Spouse Child Other**
Subscriber's Employer_____
Insurance Company Name_____
Address_____
City_____ State_____ Zip_____
Phone Number_____

Medical History

List physician name_____ Physician phone number_____
List all medications, including herbal supplements_____
_____

Are you allergic to any of the following? ____ Latex ____ Penicillin ____ Amoxicillin ____Codeine ____ Tetracycline____ Other_____

Have you been hospitalized in the past year? Y N If yes, please explain_____
Have you had any replacement valves, joints, rods, screws, stints or shunts placed? Y N If yes, please explain_____
Have you been diagnosed with a heart murmur, mitral valve prolapse or any other heart related condition? Y N If yes, please explain_____
Have you been diagnosed with cancer? Y N If yes, please explain_____
Do you have diabetes? Y N If yes, is it controlled? _____
Do you have high blood pressure? Y N If yes, is it controlled? _____
Are you taking a prescription anti-coagulant (Blood thinner) such as Coumadin? Y N If yes, please list_____
Are you taking medication for osteoporosis, such as Fosamax, Actonel, Boniva, Aredia, Zometa or Bonefos? Y N If yes, please list_____
Do you use tobacco? Y N If yes, how & how much?_____
List any other medical conditions not mentioned above_____
_____

Women: Are you pregnant? _____ If yes, how many weeks? _____

Patient Signature _____ Date_____

Doctor Signature_____ Date_____

Date	Initial	Updates to Medical History

New Patient Smile Evaluation

Patient Name_____ **Date**_____ **Dr.**_____

Means of Diagnosis	Date Taken	Examination Findings	
Panorex or FMX		Oral Cancer Screening	POSITIVE NEGATIVE
Intraoral Photos		Periodontal Type	0 1 2 3 4
Digital Photo Series		Smile Design Candidate	YES NO

When was your last visit to a dentist?_____
Are you having any discomfort?_____
When brushing do your gums bleed, become tender or irritated?_____
Have you ever been treated for gum disease?_____
Do you have missing teeth?_____
Do you wear a removable denture or partial? _____
Would you like to know more about permanent replacements?_____
Do you have unwanted gaps or spaces between your teeth?_____
Have you ever worn braces?_____
Have you had any dental surgeries?_____
Are you concerned about the discoloration of one or more teeth?_____
Have you considered bleaching your teeth?_____
Is there anything you would like to change about your smile?_____
_____

Doctor's comments:_____
_____
_____
_____

MISSING TEETH, EXISTING RESTORATIONS AND X-RAY FINDINGS