



Welcome to Our Practice

Date: _____

1. Tell us about yourself:

Name: _____ E-mail: _____
Nickname: _____ Male / Female Age: _____ DOB: _____
Responsible Party:
Name: _____ Phone: _____ Relation: _____

Who may we thank for referring you? _____

2. Contact Information:

Address: _____

Phone(h): _____ Phone(c): _____ Phone(w): _____

Emergency Contact:
Name: _____ Phone: _____ Relation: _____

3. Current Dentist:

Name: _____ Phone: _____
Last visit: _____ Address: _____

4. Primary Dental Ins.: _____ Secondary: _____

Name: _____ DOB: _____ Name: _____ DOB: _____

Address: _____ Address: _____

SS#: _____ SS#: _____

Policy#: _____ Policy#: _____

Employer: _____ Relation: _____ Employer: _____ Relation: _____

5. Dental History:

Have you had a serious/difficult problem associated with dental work? Y / N

Have you ever had pain/tenderness in the jaw joint (TMJ/TMD)? Y / N

How many times a day do you brush? Floss? Type of bristles? Hard Med. Soft

Please describe your health: Good Fair Poor Do your gums bleed? Y / N

Do you currently have a physician? Y / N Dr. _____ Phone: _____

Please list all medications you're currently taking:

Please list all drugs you're allergic to/ allergies:

For Women:

Are you on birth control? Y / N

Are you pregnant? Y / N week# _____

Are you nursing? Y / N

<u>DR. USE ONLY</u>
OCS _____
RMH _____

6. Have you ever had any of these medical problems?

Heart murmur	Y N	Hepatitis	Y N	Any hospital stays?	Y N
Cancer	Y N	Tuberculosis	Y N	Asthma	Y N
Diabetes	Y N	Prosthesis	Y N	Hemophilia	Y N
Rheum. Fev.	Y N	Congenital Heart Def.	Y N	Hearing Impairment	Y N
HIV+/ AIDS	Y N	Abnormal Bleeding	Y N		

Handicap/ Disabilities

Recent operations

“Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.”

I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and it is my responsibility to inform the office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need.

Signature of Patient/Guardian

Date