Welcome To Our Office!

ARCHIVED
Box # Date
For office use only.

Patient Information

Name ______________________________ **Social Security #** ______________
LAST NAME FIRST NAME INITIAL

Address ______________________________

City ______________ **State** ______________ **Zip** ______________

Home Phone ______________ **Business Phone** ______________ **Cell Phone** ______________

E-mail Address ______________________________ (For contacting you regarding your appointments only)

Sex ☐ **M** ☐ **F** **Age** ______ **Birthdate** ______________ ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Separated** ☐ **Divorced**

Patient Employed by ______________________________ **Occupation** ______________________________

Notify in case of emergency ______________________________ **Best Contact Number** ______________

How did you hear about our office? ☐ **Yellow Pages** ☐ **Web Site** ☐ **Dave FM Radio** ☐ **The Bull 94.9 Radio** ☐ **Mini Cooper**

☐ **Kudzu.com** ☐ **Someone you know** ______________ ☐ **Saw our sign** ☐ **Other** ______________
(NAME PLEASE)

Dental History

How do you feel about the appearance of your teeth? ______________________________

If you are in dental discomfort today, please explain ______________________________

Check if you have experienced any of the following:

☐ Bad Breath
☐ Bleeding gums
☐ Clicking or popping jaw
☐ Food collection between teeth
☐ Grinding or clenching teeth
☐ Loose teeth or broken fillings
☐ Periodontal treatment
☐ Sensitivity to cold
☐ Sensitivity to hot
☐ Sensitivity to sweets
☐ Sensitivity when biting
☐ Sores or growths in mouth

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ☐ **Y** ☐ **N**

Other information about your dental health or previous treatment ______________________________

Medical History

Are you currently under physician care? ☐ **Y** ☐ **N** **If yes, describe** ______________________________

Women: Are you pregnant? ☐ *Y* ☐ *N* *Nursing?* ☐ *Y* ☐ *N* *Taking birth control pills?* ☐ *Y* ☐ *N*

Check if you have had any of the following:

☐ AIDS/HIV Positive
☐ Anemia
☐ Artificial Heart Valve
☐ Artficial Joint
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Chemotherapy
☐ Diabetes
☐ Epilepsy
☐ Glaucoma
☐ Heart Murmur
☐ Other Heart Problems
Describe ______________
____
☐ Hepatitis A
☐ Hepatitis B
☐ Hepatitis C
☐ Herpes
☐ High Blood Pressure
☐ Latex Allergy
☐ Mitral Valve Prolapse
☐ Pacemaker
☐ Tuberculosis

Has your physician instructed you to take medication prior to a dental visit? **If yes, for what condition?** ______________

List any <u>medications</u> you are currently taking: **List <u>drug allergies:</u>**

______________________________ ______________________________

Authorization

I have reviewed the information that I have provided on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize my insurance company to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature ______________________________ **Date** ______________