

Welcome to Our Practice

Please Print

Date _____ **Adult**

Name _____ Age _____ Sex _____

Address _____ Home Phone _____

City _____ State _____ Zip Code _____ Birthdate _____

Patient _____

Spouse _____

Occupation _____

Occupation _____

Employed By _____

Employed By _____

Work Address _____

Work Address _____

Work Phone _____ ext _____

Work Phone _____ ext _____

Dental Insurance Carrier _____

Dental Insurance Carrier _____

Insurance Phone Number _____

Insurance Phone Number _____

Group Number _____

Group Number _____

Social Security Number _____

Social Security Number _____

If you have a Flex Spending Account at work, please advise.

Family Dentist _____ Date of last Dental Exam _____

Have we treated other members of your family? _____

Whom may we thank for referring you to our office? _____

In case of emergency, whom should we contact? _____ Phone _____



Please check "Yes" or "No" to each of the following questions:

		Yes	No
1.	Family Physician _____		
2.	Are you under the care of a physician at the present time? If so, for what? _____		
3.	Have you been told that you have a heart condition (Angina Pectoris, Mitral Valve Prolapse, Heart Attack, etc.) _____		
4.	Have you been told that your blood pressure is too high or too low? _____		
5.	Do you have any prosthetic heart valves or joints? _____		
6.	Have you ever had rheumatic heart disease or rheumatic fever? _____		
7.	Do you bleed abnormally following a cut or injury? _____		
8.	Are you allergic to any food, drug or medicine (or latex)? If so, what? _____		
9.	Do you have other allergies such as hay fever or asthma? _____		
10.	Do you have any lung problems (Tuberculosis, emphysema, etc.?) _____		
11.	Are you taking any pills or drugs at the present time? If so, for what? _____		
12.	Do you have a history of diabetes or hypoglycemia? _____		
13.	Have you ever been treated for epilepsy? _____		
14.	Women, are you pregnant? _____		
15.	Women, are you using oral contraceptives? _____		
16.	Have you ever taken Cortisone, steroids, or similar drugs? _____		
17.	Have you ever been treated for an emotional disturbance? _____		
18.	Do you have a history of hepatitis, jaundice or any liver disease? _____		
19.	Have you had a bone disease? _____		
20.	Have you ever had a tumor or cancer? _____		
21.	Have you ever had x-ray treatments for tumors or cancer? _____		
22.	Have you ever had an operation? If so, for what? _____		
23.	Have you ever had a disease of the eyes, ears, nose or throat? _____		
24.	Do you have a venereal disease? _____		
25.	Have you ever had any accidents to your head, face or teeth? If so, please explain. _____		
26.	Have you had any serious illnesses other than those above? If so, please explain. _____		
27.	Do you have AIDS or any other immunosuppressive disorders? _____		
28.	Have you ever had any TMJ (jaw) problems? _____		
29.	Have you ever had any kind of orthodontic treatment? _____		

Patient's Signature

Date