ADVANCED COSMETIC
AND GENERAL DENTISTRY

We warmly welcome you to our office. Please take a few moments to complete the following information so that we can better care for you. It is our goal to help you reach and maintain maximum oral health.

Name: _____

I prefer to be called:_____ Male Female

Birth date: _____ SSN:_____

Home address:_____

_____

Hm # _____ Cell #_____

Wk # _____ Pgr # _____

Email _____

How do you prefer to confirm your appointments?

_____

Employer: _____

_____

Occupation: _____

Whom may we thank for referring you? _____

Other family members seen by us?

_____

Previous / Present Dentist: _____

Date of Last Visit : _____ Ph# _____

Dental Insurance

Primary Dental Insurance

Insurance Co. Name: _____

Address: _____

Phone: _____

Group # (Plan, Local, or Policy #) _____

Insured's Name: _____

Relation: _____

Insured's Birth date: _____

Insured's SSN: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Address: _____

Phone: _____

Group # (Plan, Local, or Policy #) _____

Insured's Name: _____

Relation: _____

Insured's Birth date: _____

Insured's SSN: _____

In the event of an emergency, is there someone who lives near you that we should contact?

Name:_____

Relation:_____

Wk # _____ Hm # _____

A note for patients with dental insurance – We will assist you to maximize your insurance benefits, and we are happy to file claims to your insurance carrier and agree to accept payment from any carrier that offers an assignment of benefits, if you desire. We will do our best to calculate your available benefit amount, however, regardless of what your insurance plan pays, you are responsible for all fees.

Medical History

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

If yes, please explain: _____

Are you taking any prescription/over the counter drugs? ☐ Yes ☐ No

If yes, please list: _____

Do you use or smoke tobacco in any form? ☐ Yes ☐ No

Have you or do you take Redux/Fen Phen or Pondimin? ☐ Yes ☐ No

For women: Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No week# _____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems?

Y	N	Abnormal Bleeding	Y	N	Herpes/Fever Blisters
Y	N	Alcohol/Drug Abuse	Y	N	High Blood Pressure
Y	N	Anemia	Y	N	HIV+/AIDS
Y	N	Arthritis	Y	N	Hospitalized Any Reason
Y	N	Artificial Bones/Joints/Valves	Y	N	Kidney Problems
Y	N	Asthma	Y	N	Latex Allergy
Y	N	Blood Transfusions	Y	N	Liver Disease
Y	N	Cancer/Chemotherapy	Y	N	Low Blood Pressure
Y	N	Colitis	Y	N	Mitral Valve Prolapse
Y	N	Congenital Heart Defect	Y	N	Nervous/Anxious
Y	N	Diabetes	Y	N	Pacemaker
Y	N	Difficulty Breathing	Y	N	Psychiatric Problems
Y	N	Emphysema	Y	N	Radiation Treatment
Y	N	Epilepsy	Y	N	Rheumatic/Scarlet Fever
Y	N	Fainting Spells	Y	N	Seizures
Y	N	Frequent Headaches	Y	N	Shingles
Y	N	Glaucoma	Y	N	Sickle Cell Disease
Y	N	Hay Fever	Y	N	Sinus Problems
Y	N	Heart Attack	Y	N	Stroke
Y	N	Heart Murmur	Y	N	Thyroid Problems
Y	N	Heart Surgery	Y	N	Tuberculosis
Y	N	Hemophilia	Y	N	Ulcers
Y	N	Hepatitis	Y	N	Venereal Disease

Please list any other serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following items?

Y	N	Aspirin	Y	N	Latex
Y	N	Codeine	Y	N	Penicillin
Y	N	Dental Anesthetics	Y	N	Tetracycline
Y	N	Erythromycin	Y	N	Other

Please list any other drugs you are allergic to:

Dental History

Why have you come to the dentist today? _____

_____

Many patients consult us for a 2nd opinion. Are you currently seeing another dentist for your dental needs? ☐ Yes ☐ No

If Yes, please explain: _____

How would you describe the condition of your teeth and gums?
☐ Good ☐ Fair ☐ Poor

Are you currently in pain or discomfort with your teeth or gums?
☐ Yes ☐ No If yes, please explain:_____

How often do you brush your teeth? _____ Floss? _____

Do your gums bleed when you brush? ☐ Yes ☐ No

Do your gums bleed when you floss? ☐ Yes ☐ No

Have you ever experienced pain in you jaw joint? ☐ Yes ☐ No

Have you ever been treated for TMJ symptoms? ☐ Yes ☐ No

If yes, please explain: _____

Do you grind or clench your teeth? ☐ Yes ☐ No

I understand that this information is correct to the best of my knowledge. I understand it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.

I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. I also give permission for the doctor or their staff to use any photos taken for lecturing, publishing, educational, or promotional purposes.

Signature _____ Date _____

Patient portion is due in full at the time of treatment.

Updated Medical History/Consent

*Signature*_____ *Date* _____

*Signature*_____ *Date* _____

*Signature*_____ *Date* _____

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