**Welcome! Our practice is prevention oriented and dedicated to your health and well being. We are committed to providing superior dental care and are proud of our dedication to our patients. Our goal is to help you feel and look your best while focusing on long-term dental health.**

Name:________________________________________ Nickname:____________________________

Address:______________________________________________________________________________

Home Telephone:_________________ Cell:_____________________ Work:___________________

**E-mail Address:**____________________________________________ DOB:________________

Sex: Male Female **Circle One:** Single Married Divorced Widowed Partnered

Occupation:_________________________________________________________________________

Employer:__________________________________________________________________________

Emergency Contact:____________________________Telephone #:___________________________

Previous Dentist: _______________________________Telephone #:__________________________

Last dental visit: _____________Last Cleaning Appt:______________ Last X-rays:_____________

Have you had any serious trouble with dental treatments?__________________________________

Have you ever had periodontal treatment or are you currently being treated by a periodontist?

No Yes, If yes, Dr.'s name____________________________________________________

Primary Care Physician:_____________________________________ Tel #:____________________

Name Address

## If you have dental insurance, please fill out the section below:

Insurance Co.:_______________________________________ ID#:_____________________

Subscriber:_____________________________________________________________________

Subscriber DOB:_____________________ SS#:_________________________________

Employer:______________________________________________________________________

Name Address

## Office Policies (please initial)

____**Cancellation Policy:** As a courtesy, you will receive a reminder call one/two days prior to all appointments. It is your responsibility to remember your appointments. If you are unable to keep your appointment, please provide 2 business days to avoid a cancellation fee of $40. This fee is not covered by insurance.

____**Accounts Policy**: Payment is expected in full on the day of service. This includes any co-pay and/or deductible for those with dental insurance. Cash, Check, MC/Visa and Discover are welcome. We also offer Care Credit (information is available upon request).

____**Your Dental Policy:** Please understand that it is not the responsibility of our office to know each and every dental insurance policy. The most up-to-date insurance information is necessary to submit insurance claims. It is your responsibility to know your own policy and to notify us of any changes to your policy.

____**Resin Fillings Policy:** I have read/understand the waiver regarding the placement of white resin fillings.

## Medical History

**Do you have or have you ever had: (Please circle all that apply)**

Kidney trouble..................yes no
Hepatitis/Liver disease...........yes no
Stomach Trouble/Ulcers..........yes no
Thyroid Problems...................yes no
High/Low Blood pressure.......yes no
Stroke....................................yes no
Heart Murmur/ Pacemaker.......yes no
Prosthetic Cardiac Valve(s)......yes no
Stents/Valve replacement........yes no
Mitral Valve Prolapse.............yes no
Endocarditis............................yes no
Rheumatic Fever......................yes no
Sexually Transmitted Disease..yes no
AIDS/HIV................................yes no
Tuberculosis.............................yes no
Asthma....................................yes no
Respiratory Problems..............yes no
Swelling of ankles...................yes no
Diabetes..................................yes no
Rheumatoid Arthritis...............yes no
Chron's Disease.........................yes no
Immune System Deficiency..... yes no
Epilepsy/Fainting......................yes no
Radiation/ Chemotherapy.........yes no
Cancer or Tumor.......................yes no
Hemophilia.............................yes no
Mental Health Problems...........yes no
HPV..........................................yes no

WOMEN: Are you pregnant.....................yes no

Do you have any diseases or conditions not listed above? ________________________________

Please List any major surgeries or illness:____________________________________________

| Current Medication(s): | Allergies: |
|---|---|
| | |
| | |
| | |
| | |

Do you smoke cigarettes, cigars, pipe or chew tobacco? No Yes, How many packs?_________ Have you EVER smoked/chewed tobacco products? Yes No

Do you drink alcohol?.......................No Yes: How much daily?_______ Weekly?________

Do you see your Primary Care Physician (PCP) regularly? Yes No

Are you currently being treated by a Physician or Specialist (*Other* than PCP)? Yes No

Dr.'s Name________________ If so, please explain____________________________________

Has your physician recommended antibiotics before dental treatment.........No Yes

If Yes, please explain____________________________________________________________

**Please circle is you are having problems with:**

Bad Breath | Food Collecting Between Teeth | Growths In Mouth | Loose Teeth
Bleeding Gums | Grinding or Clenching Teeth | Sensitivity to Hot/Cold | Broken Fillings
Clicking/Popping Jaw | Sensitivity To Sweets | Bad Taste In Mouth | Difficulty Chewing

If you could make any changes to your smile what would they be?_________________________

_____________________________________________________________________________

**Signature:**_____________________________ **Date:**______________________________