Welcome to our office!

We'd appreciate it if you would fill in this confidential information letter Today's Date _____

My Name _____ Date of Birth _____ Work Phone _____

My Address _____ city _____ Zip _____ Home Phone _____ /Cell _____

My immediate dental concerns _____

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

My last dental examination was _____ The person responsible for my account is _____

I (have/don't have) Dental Insurance with _____

Name of Insured _____ Insured SS# _____

Policy or Group # _____ Insured's Birthdate _____

Name of Insured's Employer and Address _____

Occupation _____

I (have/don't have) a Second Dental Insurance with _____

Name of Insured _____ Insured's Birthdate _____

Policy or Group # _____ Insured SS# _____

Name of Insured's Employer and Address _____

My Marital Status _____ Spouse's Name _____ Children's Names _____

My Physician's Name _____ My last visit was for _____ Date _____

His/Her Address is _____

In case of emergency notify _____ Who is my _____ (relationship) at _____ (phone number)

I have had or have: (please circle)

Heart Failure	Artificial Joint	Sinus Trouble	Glaucoma	Venereal Dissease
Heart Disease or Attack	Anemia	Allergies or Hives	Pain in Jaw Joints	(Syphilis, Gonorrhea)
Angina Pectoris	Stroke	Diabetes	HIV Positive	Cold Sores
High Blood Pressure	Kidney Trouble	Thyroid Disease	Hepatitis A (infectious)	Herpes
Heart Murmur	Ulcers	Radiation Treatment	Hepatitis B (Serum)	Epilepsy or Seizures
Rheumatic Fever	Emphysema	Chemotherapy	Liver Disease	Fainting or Dizzy Spells
Congenital Heart Lesions	Cough	Cancer, Leukemia	Yellow Jaundice	Nervousness
Scarlet Fever	Tuberculosis (TB)	Arthritis	Blood Transfusion	Psychiatric Treatment
Artificial Heart Valve	Asthma	Rheumatism	Drug Addiction	Sickle Cell Disease
Heart Pacemaker	Hay Fever	Cortisone Medicine	Hemophilia	Bruise Easily
Heart Surgery		Growth or Tumor	Mitral Valve Prolapse	None of the Above

I have been hospitalized? ❒ Yes ❒ No For what?

I am allergic (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any drugs, medications or anesthetics ..... Yes ❒ No ❒

I have had excessive bleeding requiring special treatment ..... Yes ❒ No ❒

Are you taking any medication now? Yes ❒ No ❒ For what purpose? _____

Names of medications _____

I am pregnant Yes ❒ No ❒ How long? _____

I am dissatisfied with the appearance of my teeth? Yes ❒ No ❒ What I would change _____

I have had braces ..... Yes ❒ No ❒

Gum treatment ..... Yes ❒ No ❒

Root Canal treatment ..... Yes ❒ No ❒

I clench or grind my teeth during the day or night? ..... Yes ❒ No ❒

I have had pain in my jaw joint or my face (in and about my ears)? ..... Yes ❒ No ❒

My gums bleed when brushing? ..... Yes ❒ No ❒

I have had gum disease? ..... Yes ❒ No ❒

My mouth or teeth are sensitive to ..... **Pressure** Yes ❒ No ❒ **Cold** Yes ❒ No ❒ **Hot** Yes ❒ No ❒

My food catches between my teeth? ..... Yes ❒ No ❒

Please add anything you feel is important for the doctor to know _____

Indicate any disease, condition, or problem not listed above that you think we should know about _____

The above information is correct to the best of my knowledge, thanks for your concern.

Signature _____ Reviewed by Doctor _____