WELCOME

Do you have any full mouth x-rays?
YES/NO
When was your last dental visit? ______________

The benefits of a happy, healthy smile are immeasureable! Our goal is to help you reach and maintain maximum oral health. (Please fill out this form completely.) The better we communicate, the better we can care for you.

1 ABOUT YOU

Today's Date ______________

Name: ______________ (LAST / FIRST / MI)

I prefer to be called ______________ ☐ Male ☐ Female

Birthdate ___/___/___ Age ______ SS #: ______________

Home Address ______________ APT / CONDO #

______________ CITY / STATE / ZIP

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home #: ______________ Pager / Other #: ______________

WK #: ______________ Ext ______________

Employer: ______________

Who may we **Thank** for referring you? ______________

Other family members seen by us: ______________

2 DENTAL INSURANCE

Primary Dental Insurance

Insurance Co. Name: ______________

Group # (Plan, Local or Policy #): ______________

3 SPOUSE INFORMATION

Their Name: ______________

Employer: ______________

Birthdate: ___/___/___ SS #: ______________

Dental Insurance (Please circle) Y N

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

Their Name: ______________ Relation: ______________

WK #: ______________ HM #: ______________

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help.

4 DENTAL HISTORY

Why have you come to the dentist today? ______________

____

Are you currently in pain? ☐ No ☐ Yes

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ No ☐ Yes

Do you like your smile? ☐ No ☐ Yes Do you gums ever bleed? ☐ No ☐ Yes

How many times a week do you floss? ______ a day do you brush? ______

Type of bristles? ☐ Hard ☐ Medium ☐ Soft

5 MEDICAL HISTORY

Please use other side if necessary.

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

Please explain ______________

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

Please list each one ______________

For Women

Are you taking birth control pills? ☐ No ☐ Yes

Are you pregnant? ☐ No ☐ Yes Week # ______________

Are you nursing? ☐ No ☐ Yes

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

Y N Heart Attack / Stroke
Y N Cancer / Chemotherapy
Y N Heart Murmur
Y N Rheumatic Fever
Y N HIV+ / AIDS
Y N Heart Surgery / Pacemaker
Y N Shingles
Y N Mitral Valve Prolapse
Y N Kidney Problems
Y N Artificial Bones / Joints
Y N Artificial Valves
Y N Sinus Problems
Y N High / Low Blood Pressure
Y N Fever Blisters
Y N Severe / Frequent Headaches
Y N Psychiatric Problems
Y N Epilepsy / Seizures / Fainting Spells
Y N Diabetes / Tuberculosis (TB)
Y N Drug / Alcohol Abuse
Y N Venereal Disease
Y N Hemophilia / Abnormal Bleeding
Y N Ulcers / Colitis
Y N Congenital Heart Defect
Y N Anemia / Radiation Treatment
Y N Asthma / Arthritis
Y N Difficulty Breathing
Y N Hospitalized for Any Reason
Y N Hepatitis
Y N Blood Transfusion
Y N Emphysema / Glaucoma

____

____

Are you allergic to any of the following drugs?

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

Please list any other drugs that you are allergic to ______________

____

Physician's Name: ______________ Telephone #: ______________

State law required that we obtain your consent for treatment. There are risks associated with any dental treatment. These include, bleeding, failure of wound to heal, injuries to adjacent teeth or structures, incomplete removal of tooth, dry socket, loss of teeth, loss of bone, instrument breakage, breakage of roots, retained root fragements, swallowing or aspirating of objects, allergic reactions to drugs, jaw pain, pain in opening mouth, failure of treatment to accomplish its purpose, numbness of tongue or mouth, death, and bacterial endocarditis.

I acknowledge that I have read and understand the information contained on this form. I hereby authorize the dentists, hygienists, and assistants of their choice to perform diagnostic, surgical and dental treatment. Furthermore, if I have insurance coverage, I authorize release of any information relating to insurance claims. I understand that I am responsible for all costs of dental treatment.

Signed ______________________________ Date ______________
(Patient or Parent if minor)

I HEREBY AUTHORIZE PAYMENT directly to Richard L. Herman DDS of the group insurance benefits otherwise payable to me.

Signed ______________________________ Date ______________

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Payment is due in full at the time of treatment unless prior arrangements have been approved.

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I verbally reviewed the medical / dental information above with the patient named herein. Initials ______________ Date ______________

MEDICAL HISTORY UPDATE

1. Date __________ Comments ______________________ Signature ______________________
2. Date __________ Comments ______________________ Signature ______________________
3. Date __________ Comments ______________________ Signature ______________________
4. Date __________ Comments ______________________ Signature ______________________
5. Date __________ Comments ______________________ Signature ______________________