WELCOME

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

1 About You

Today's Date ____________

Name ____________
LAST FIRST MI MR MRS MS DR

I prefer to be called ____________ ☐ Male ☐ Female

Birthdate ____________ Age ______ SS # ____________

Home Address ____________
APT/CONDO #

City/State/Zip ____________

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home # ____________ Cell Phone # ____________

Wk # ____________ Ext. ______ DL # ____________

Where & when are best times to reach you? ____________

Employer ____________

Employer's Address ____________

How long there? ______ Occupation ____________

Whom may we Thank for referring you? ____________

Other family members seen by us ____________

Previous / Present Dentist ____________
(Please Circle)

Last Visit Date ____________

2 Spouse Information

His/Her Name: ____________

Employer: ____________

WK #: ____________ **Ext** ______ **SS #:** ____________

Birthdate: ____________ **DL #:** ____________

Person Responsible for Account: ____________

WK #: ____________ **Ext** ______ **HM #:** ____________

Billing Address: ____________
Zip

Relationship: ____________ **SS #:** ____________

Employer: ____________ **DL #:** ____________

3 Dental Insurance

Primary Dental Insurance

Insurance Co. Name: ____________

Insurance Co. Address: ____________

Insurance Co. Phone #: ____________

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

Insured's Name: ____________ **Relation:** ____________

Insured's Birthday: ___ / ___ / ___ **Insured's SS #:** ____________

Insured's Employer: ____________

Secondary Dental Insurance

Insurance Co. Name: ____________

Insurance Co. Address: ____________

Insurance Co. Phone #: ____________

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

Insured's Name: ____________ **Relation:** ____________

Insured's Birthday: ___ / ___ / ___ **Insured's SS #:** ____________

Insured's Employer: ____________

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

Their Name ____________ Relation ____________

Home # ____________ Work # ____________

4 Medical History

Do you have a personal physician? ☐ No ☐ Yes

Physician's Name: ____________

Phone #: ____________ **Date of last visit:** ____________

CONTINUED ON BACK OF FORM

4 MEDICAL HISTORY *continued*

Your current physical health is ☐ Good ☐ Fair ☐ Poor

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 ______

Do you need to take antibiotic premedication before dental treatment? ☐ No ☐ Yes

For Women Are you taking birth control pills? ☐ No ☐ Yes

Are you pregnant? ☐ No ☐ Yes Week # ______

Are you nursing? ☐ No ☐ Yes

Please circle Yes or No to 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

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

______

______

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
Y N Other

Please list any other drugs that you are allergic to: ______

______

5 DENTAL HISTORY

Why have you come to the dentist today? ______

______

______

Are you currently in pain? ☐ No ☐ Yes

Have you ever had a serious/difficult problem associated with any previous dental work? ☐ No ☐ Yes

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

Your current dental health is ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ No ☐ Yes

Do your gums ever bleed? ☐ No ☐ Yes

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

Type of bristles? ☐ Hard ☐ Medium ☐ Soft

6

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest 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, with my informed consent, that I may need during diagnosis and treatment.

______

Signature **Date**

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

7 Acknowledgment of Offer of Privacy Practices Notice

I acknowledge that I have been offered a Notice of Privacy Practices from the office of Ron Cowles, D.D.S.

______

Signature **Date**

DATE	Medical History Update