

WELCOME

YOUNG ADULT

WE WOULD LIKE TO WELCOME YOU TO OUR OFFICE. OUR GOAL IS TO MAKE EVERY VISIT PLEASANT AND EDUCATIONAL. WE STRIVE TO TEACH GOOD ORAL CARE THAT WILL ENABLE YOU TO HAVE A BEAUTIFUL SMILE THAT LASTS A LIFETIME.

TELL US ABOUT YOU:

TODAY'S DATE: _____

NAME: _____

NICKNAME: _____ MALE / FEMALE

BIRTHDATE: ____/____/____ AGE: _____

SCHOOL: _____ GRADE: _____

HOBBIES/SPORTS: _____

HOME PHONE: (____) _____

CELL PHONE: (____) _____

HOME ADDRESS: _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PREVIOUS/PRESENT DENTIST _____

LAST VISIT DATE: _____

PERSON RESPONSIBLE FOR MAKING APPOINTMENTS:

NAME: _____

WORK PHONE: (____) _____

HOME PHONE: (____) _____

ADDRESS: _____

RELATIONSHIP TO PATIENT: _____

PRIMARY DENTAL INSURANCE:

INSURANCE CO. NAME: _____

INSURANCE CO. ADDRESS _____

INSURANCE CO. PHONE #: (____) _____

GROUP OR POLICY #: _____

POLICY OWNER'S NAME: _____

RELATIONSHIP TO PATIENT: _____

POLICY OWNER'S BIRTHDATE: ____/____/____ SSN: _____

POLICY OWNER'S EMPLOYER: _____

EMPLOYER'S ADDRESS: _____

-PARENT INFORMATION:

WHO IS ACCOMPANYING YOU TODAY? _____

NAME: _____ RELATION: _____

DOES THIS PERSON HAVE LEGAL CUSTODY OF YOU? YES / NO
PARENT'S MARITAL STATUS: (PLEASE CIRCLE) SINGLE / WIDOW
MARRIED / REMARRIED / DIVORCED / SEPARATED

MOTHER'S INFORMATION: STEP / GUARDIAN

NAME: _____ BIRTHDATE ____/____/____

SSN # _____

WORK PHONE(____) _____ HOME PHONE (____) _____

CELL (____) _____ E-MAIL _____

EMPLOYER: _____

FATHER'S INFORMATION: STEP / GUARDIAN

NAME: _____ BIRTHDATE ____/____/____

SSN # _____

WORK PHONE(____) _____ HOME PHONE (____) _____

CELL (____) _____ E-MAIL _____

EMPLOYER: _____

PERSON RESPONSIBLE FOR ACCOUNT:

NAME: _____ RELATION _____

EMPLOYER: _____

WORK PHONE(____) _____ HOME PHONE (____) _____

CELL (____) _____ E-MAIL _____

BILLING ADDRESS: _____

SECONDARY DENTAL INSURANCE:

INSURANCE CO. NAME: _____

INSURANCE CO. ADDRESS _____

INSURANCE CO. PHONE #: (____) _____

GROUP OR POLICY #: _____

POLICY OWNER'S NAME: _____

RELATIONSHIP TO PATIENT: _____

POLICY OWNER'S BIRTHDATE: ____/____/____ SSN: _____

POLICY OWNER'S EMPLOYER: _____

EMPLOYER'S ADDRESS: _____

Why have you come to the dentist today and/or what are your main concerns? _____

Have you experienced problems with previous dental work? Yes ___ No ___
Is your water fluoridated? Yes ___ No ___
Are you taking fluoridated supplements? Yes ___ No ___
Have you ever had any pain/tenderness in your jaw joint? (TMJ/TMD) Yes ___ No ___
Do you brush your teeth daily? Yes ___ No ___
Floss your teeth daily? Yes ___ No ___
Do your gums bleed? Yes ___ No ___
Do you need to be premedicated before dental work? Yes ___ No ___
Are you currently under the care of a physician? Yes ___ No ___
Physician's name: _____

Phone: _____ Last visit: _____

Please describe your current physical health: (circle one)
Good Fair Poor

Please list all drugs you are currently taking: _____

For Women:
*Are you taking birth control pills? Yes ___ No ___
*Are you pregnant? Yes ___ No ___ Unsure ___ Week # ___
*Are you nursing? Yes ___ No ___

Have you ever been evaluated / had orthodontic treatment before? Yes ___ No ___
Have there been any injuries to your face, mouth, teeth, or chin? Yes ___ No ___
Have adenoids or tonsils been removed? Yes ___ No ___
Have you been informed of any missing or extra permanent teeth? Yes ___ No ___
Have you played any musical instruments? Yes ___ No ___
If so, what? _____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING:

Y N Aspirin
Y N Any Metal
Y N Plastic
Y N Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Latex
Y N Penicillin
Y N Tetracycline
Y N Other
Please list any other Allergies: _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING

MEDICAL CONDITIONS:
Y N Abnormal Bleeding
Y N Anemia
Y N Any Hospital Stays
Y N Asthma
Y N Cancer
Y N Chicken Pox
Y N Congenital Heart Defect
Y N Convulsions
Y N Epilepsy
Y N Diabetes
Y N Exposed to HIV, but neg.
Y N Disabilities
Y N Hearing Impairment
Y N Heart Murmur
Y N Hemophilia
Y N Hepatitis
Y N Hives
Y N HIV+/AIDS
Y N Immunizations current
Y N Kidney Problems
Y N Liver Problems
Y N Measles
Y N Mononucleosis
Y N Mitral Valve Prolapse
Y N Rheumatic/Scarlet Fever
Y N Skin Rash
Y N Tuberculosis (TB)

DID/DO YOU HAVE ANY OF THE FOLLOWING HABITS?

Y N Nursing Bottle Habits
Y N Speech Problems
Y N Thumb/Finger Sucking
Y N Tongue Thrust
Y N Grinding Teeth
Y N Lip Sucking/Biting
Y N Mouth Breather
Y N Nail Biting
Y N Used Pacifier

I understand that I am responsible (if over 18 yrs.) for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance or my parent's insurance does not cover.

Patient Signature (if over 18 yrs.) Date

Parent/Guardian Signature (if necessary) Date

I affirm that the information I have given is correct to the best of my knowledge. It 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 the necessary dental services I may need.

Signature of Patient and/or Parent/Guardian Date

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