WELCOME

We are pleased to welcome you to our office. Our goal is to help you reach and maintain maximum dental health. Please fill out this form as completely as you can. If you have any questions or need assistance, please ask - we will be happy to help.

ABOUT YOU

Name: _____

I prefer to be called: _____

Male ☐ Female ☐

Birthdate: _____ SS# ____ - __ - ____

Home Address: _____

City _____ State _____ Zip _____

Single ☐ Married ☐ Divorced ☐ Widowed ☐

Home Phone: _____

Work Phone: _____ Ext. _____

Cell Phone: _____

E-mail Address: _____

Employer's Name: _____

Occupation: _____

How did you hear about our office?

Emagine Theater ☐ ***Post-card*** ☐ ***Internet/Website*** ☐ ***Bill-board*** ☐

Bldg Sign ☐ ***Friend*** ☐ ***1-800*** ☐ ***Family*** ☐

Name of Family or Friend for us to send our thanks to them. _____

PERSON RESPONSIBLE FOR ACCOUNT

(if different from above)

Name: _____

Billing Address: _____

Relationship: _____ SS# ____ - __ - ____

Is this person a patient in our office? Yes☐ No☐

SPOUSE INFORMATION

Spouse's Name: _____

Employer: _____

Work Phone: _____ Ext. _____

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: _____ 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: _____ SS#: ____-__-____

Insured's Employer: _____

MEDICAL HISTORY

Do you have a personal physician? Yes ☐ No ☐

Physician's Name: _____

Date of last visit: _____

Are you currently under his/her care? Yes ☐ No ☐

If Yes, for what condition? _____

Do you use or chew tobacco? Yes ☐ No ☐

Do you take vitamins? Yes ☐ No ☐

Are you taking ANY medications? Yes ☐ No ☐

Please list each one _____

_____

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

Y	N	Anemia / Hemophilia	Y	N	Circle: Heart Attack, Stroke or Murmur
Y	N	Asthma / Hay Fever	Y	N	Heart Problem
Y	N	Arthritis	Y	N	Hepatitis/Liver Disease
Y	N	Circle: Artificial Bones, Joints or Valves	Y	N	High Blood Pressure
Y	N	Cancer-Date _____	Y	N	HIV+ / AIDS
Y	N	Diabetes	Y	N	IV Bisphosphonates
Y	N	Drug / Alcohol Abuse	Y	N	Mitral Valve Prolapse
Y	N	Ear / Nose / Sinus	Y	N	Radiation Treatment
Y	N	Emphysema / TB	Y	N	Rheumatic Fever
Y	N	Epilepsy	Y	N	Severe/Freq. Headache
Y	N	Esophageal Reflux	Y	N	Stomach / Intestinal
Y	N	Fever Blister/Cold Sore	Y	N	Thyroid

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

_____

Are you allergic to any of the following?

Y	N	Penicillin	Y	N	Tetracycline	Y	N	Latex
Y	N	Aspirin	Y	N	Dental Anesthetics	Y	N	Sulfa
Y	N	Erythromycin	Y	N	Codeine	Other: _____		

FOR WOMEN Are you pregnant? Yes ☐ No ☐

Do you take birth control pills? Yes ☐ No ☐

Are you nursing? Yes ☐ No ☐

DENTAL HISTORY

Why have you come to the dentist today?

_____

Are you currently in pain? Yes ☐ No ☐

Have you ever experienced pain or discomfort in your jaw? Yes ☐ No ☐

Do you clench or grind your teeth? Yes ☐ No ☐

Do you have any sores or lumps in or near your mouth? Yes ☐ No ☐

Have you had orthodontic treatment? Yes ☐ No ☐

Do you wear dentures or partials? Yes ☐ No ☐

Do your gums ever bleed? Yes ☐ No ☐

Have you ever had periodontal treatment for your gums? Yes ☐ No ☐

Is bad breath or taste a problem for you? Yes ☐ No ☐

How many times a day do you brush? __

How many times a week do you floss?__

How would you rate your smile on a scale of 1 (not satisfied) to 10 (love it, just the way it is)? _____

Release of Information/Consent for Treatment

I give consent for dental treatment to Dr. Booker and his staff for the patient named on this form. I authorize Dr. Booker and staff to release any and all information contained in my records to any third party payer or insurance carriers which may be responsible for paying any expenses associated with my treatment. If this is a minor child, I give permission to Dr. Booker to post this child's portrait on the No Cavity Club page of our website DownriverSmiles.com.

Signature of Patient, Parent or Guardian _____

Date _____