

# 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 us - 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?

Yellow Pages  Website  Print Ad

Sign  Postcard  1-800-DENTIST

Who Referred You? \_\_\_\_\_

## 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: \_\_\_\_\_

## PERSON RESPONSIBLE FOR ACCOUNT

(if different from above)

Name: \_\_\_\_\_

Billing Address: \_\_\_\_\_

Relationship: \_\_\_\_\_ SS# \_\_\_\_ - \_\_ - \_\_\_\_

Is this person a patient in our office? Yes  No



### 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 now or have you used 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 problems?

Y	N	Anemia / Hemophilia	Y	N	Fever Blister/Cold Sore
Y	N	Asthma / Hay Fever	Y	N	Heart Attack / Stroke
Y	N	Arthritis	Y	N	Heart Murmur
Y	N	Artificial Bones / Joints	Y	N	Heart Problem
Y	N	Artificial Valves	Y	N	Hepatitis/Liver Disease
Y	N	Cancer-Date _____	Y	N	High Blood Pressure
Y	N	Diabetes	Y	N	HIV+ / AIDS
Y	N	Drug / Alcohol Abuse	Y	N	Mitral Valve Prolapse
Y	N	Ear / Nose / Sinus	Y	N	Rheumatic Fever
Y	N	Emphysema / TB	Y	N	Severe/Freq. Headache
Y	N	Epilepsy	Y	N	Stomach / Intestinal
Y	N	Esophageal Refex	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. Hartwell and his staff for the patient named on this form. I authorize Dr. Hartwell 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. Hartwell to post this child's portrait on the No Cavity Club page of our website DownriverSmiles.com.

Signature of Patient, Parent or Guardian \_\_\_\_\_

Date \_\_\_\_\_