Welcome to our office! Our goal is to make your visit enjoyable and educational.
We want you to have a healthy & beautiful smile that will last a lifetime!

About you:

Name: ____ Birth date: ____/____/______
mo. day yr.

Address: ____ Zip: ______________

Cell #: _____-______-_________ Alternate: Cell / Home / Work / Spouse _____-______-__________

❑ Check this box to opt OUT of text appointment reminders ↑circle one↑

Email: ____

❑ Check this box to opt OUT of email appointment reminders

How and when is the best time to reach you? _______________________________________

How did you hear about us? ____

Who is your General Dentist? ____

Are you: ❑ Single ❑ Married ❑ Widowed ❑ Divorced

If married, Spouse's name: _____________________________ Cell #: _____-______-_______

Emergency Contact Name: _____________________________ Cell #: _____-______-_______

Person Responsible for the Account: *please fill out the info below if not already noted above.

Name: _____________________________________ Relationship to Patient: _______________

Billing Address: ____ Zip: _______________

Cell #: _____-______-_________ Alternate: Cell / Home / Work / Spouse _____-______-__________

↑circle one↑

Email: ____

Do you have dental insurance? Yes / No If yes, please fill out our insurance form.

Dental & Medical History

Patient Name: ____

Chief Concern(s): ____

Do your gums bleed? Yes / No

Can you chew on both sides of your mouth? Yes / No

Have you ever been treated by an Orthodontist before? Yes / No

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

Heart Attack / Stroke	Y / N	Sinus Problems	Y / N
Artificial Valves	Y / N	Severe/Frequent Headaches	Y / N
Heart Murmur	Y / N	Fever Blisters/Cold Sores	Y / N
Heart Surgery	Y / N	Psychiatric Problems	Y / N
Mitral Valve Prolapse	Y / N	Epilepsy/Seizures/Fainting	Y / N
High/Low Blood Pressure	Y / N	Tuberculosis (TB)	Y / N
Congenital Heart Defect	Y / N	Drug/Alcohol Abuse	Y / N
Cancer/ Chemotherapy	Y / N	Hemophilia/Abnormal Bleeding	Y / N
Diabetes	Y / N	Anemia	Y / N
Rheumatic Fever	Y / N	Asthma	Y / N
Shingles	Y / N	Arthritis	Y / N
Kidney Problems	Y / N	Difficulty Breathing	Y / N
Artificial Bones	Y / N	Hepatitis	Y / N
Radiation Treatment	Y / N	Blood Transfusion	Y / N
HIV/AIDS	Y / N	Snoring/Apnea	Y / N

If yes to ANY of the above, please explain:____

____

Do you require antibiotic coverage prior to your dental appointments? Yes / No

Please circle any of the following drugs you may be allergic to:

Penicillin   Aspirin/Ibuprofen   Tetracycline   Ciprofloxacin Hydrochloride

Codeine   LATEX   Erythromycin

List any **other** drugs you are allergic to:____

Please list any medication that you are presently taking:______________________________

____

I understand that the information that I have given today is correct to the best of my knowledge.

Signature:____ Date:____________