

Welcome

ABOUT YOU

Today's Date _____ E-mail Address _____

Name _____ I prefer to be called _____ Male Female
Last First MI Mr Mrs Ms Dr

Birthdate ____/____/____ Age _____ Social Security # _____ Single Married Divorced Widowed Separated

Home Address _____
Street City State Zip

Home Phone # (____) _____ Pager/Car # (____) _____ Work Phone # (____) _____ Ext _____ Driver's License # _____

Where & when are best times to reach you? _____ Whom may we Thank for referring you? _____

Other family members seen by us: _____

Employer _____ How long there? _____ Occupation _____

Employer's Address _____
Street / PO Box City State Zip

Neighbor or Relative not living with you

His / Her Name _____ Relation _____ Work Phone# (____) _____ Home Phone # (____) _____

Address _____
Street City State Zip

Person Responsible for Account if other than yourself

Name _____ Relation _____ Home Phone # (____) _____ Social Security # _____

Employer _____ Work Phone # (____) _____ Ext _____ Driver's License # _____

Billing Address _____
Street City State Zip

SPOUSE INFORMATION

His / Her Name _____ Birthdate ____/____/____ Social Security # _____

Employer _____ Work Phone # (____) _____ Ext _____ Driver's License # _____

INSURANCE INFORMATION

Primary Insurance Medical Coverage? Yes No Dental Coverage? Yes No Orthodontic Coverage? Yes No

Insurance Co. Name _____ Phone # (____) _____ Group # (Plan, Local or Policy #) _____

Insurance Co. Address _____
Street / PO Box City State Zip

Insured's Name _____ Insured's Social Security # _____ Birthdate ____/____/____ Relation _____

Insured's Employer _____ Employer's Address _____
Street / PO Box City State Zip

Secondary Insurance Medical Coverage? Yes No Dental Coverage? Yes No Orthodontic Coverage? Yes No

Insurance Co. Name _____ Phone # (____) _____ Group # (Plan, Local or Policy #) _____

Insurance Co. Address _____
Street / PO Box City State Zip

Insured's Name _____ Insured's Social Security # _____ Birthdate ____/____/____ Relation _____

Insured's Employer _____ Employers Address _____
Street / PO Box City State Zip

Continued on Back

DENTAL HISTORY

Why have you come to the dentist today? _____

- Are you currently in pain? Yes No
- Do you require antibiotics before dental treatment? Yes No
- Have you experienced problems associated with any previous dental work? Yes No
- Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ / TMD)? Yes No
- Your current dental health is Good Fair Poor
- Do you floss daily? Yes No
Brush daily? Yes No
- Type of bristles on your toothbrush? Hard Medium Soft
- How long do you use a toothbrush before replacing it? _____
- Do you use anything in addition to your brush and floss? Yes No
If yes, what? _____

- Would you like Whiter teeth? Yes No
- Do your gums ever bleed? Yes No
- Do you have mobility in your teeth? Yes No
- Have you ever had periodontal disease? Yes No
- Are your teeth sensitive to heat, cold, or anything else? _____
- Do you still have wisdom teeth? Yes No
- If yes, why? _____
- Previous / Present Dentist _____ Last Visit Date _____
Please circle
- Why did you leave your previous dentist? _____
- What did you like most and least about any dentist you have seen? _____

Are you happy with the way your smile looks? Yes No

If not, what would you change? _____

MEDICAL HISTORY

- Do you have a personal physician? Yes No
- Physician's Name _____
- Address _____
Street City State Zip
- Phone # (____) _____ Date of last visit _____
- Your current physical health is** Good Fair Poor
- Are you currently under the care of a physician? Yes No
- Please explain _____
- Do you smoke or use tobacco in any other form Yes No

- Are you allergic to any of the following?**
- | | | |
|------------------------|----------------------|------------------|
| Y N Aspirin | Y N Erythromycin | Y N Sedatives |
| Y N Barbiturates | Y N Jewelry / Metals | Y N Sulfa Drugs |
| Y N Codeine | Y N Latex | Y N Tetracycline |
| Y N Dental Anesthetics | Y N Penicillin | Y N Other |
- Please list additional drugs/materials that cause allergic reactions _____

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

Are you taking any of the following?

- | | | | |
|--------------------|--------------------------------|----------------------------|----------------------|
| Y N Acetaminophen | Y N Blood Thinners | Y N Insulin/Diabetes Drugs | Y N Thyroid Medicine |
| Y N Antibiotics | Y N Blood Pressure Medication | Y N Nitroglycerin | Y N Tranquilizers |
| Y N Antihistamines | Y N Cold Remedies | Y N Recreational Drugs | |
| Y N Aspirin | Y N Digitalis/Heart Medication | Y N Steroids/Cortisone | |
- Are you taking any prescription / over-the-counter-drugs not listed above? Yes No If yes, please list each one _____

Do you or have you experienced the following?

- | | | | | |
|-----------------------------|-----------------------------|---------------------------------|---------------------------|-------------------------|
| Y N Abnormal Bleeding | Y N Colitis | Y N Headaches | Y N Kidney Problems | Y N Seizures |
| Y N Alcohol Abuse | Y N Congenital Heart Defect | Y N Heart Attack | Y N Liver Disease | Y N Shingles |
| Y N Anemia | Y N Diabetes | Y N Heart Murmur | Y N Low Blood Pressure | Y N Sickle Cell Disease |
| Y N Arthritis | Y N Difficulty Breathing | Y N Heart Surgery | Y N Lupus | Y N Sinus Problems |
| Y N Artificial Bones/Joints | Y N Drug Abuse | Y N Hemophilia | Y N Mitral Valve Prolapse | Y N Steroid Therapy |
| Y N Artificial Valves | Y N Emphysema | Y N Hepatitis | Y N Pacemaker | Y N Stroke |
| Y N Asthma | Y N Epilepsy | Y N Herpes | Y N Persistent Cough | Y N Thyroid Problems |
| Y N Blood Transfusion | Y N Fainting Spells | Y N High Blood Pressure | Y N Psychiatric Problems | Y N Tonsillitis |
| Y N Cancer | Y N Fever Blisters | Y N HIV+/AIDS | Y N Radiation Treatment | Y N Tuberculosis (TB) |
| Y N Chemotherapy | Y N Glaucoma | Y N Hospitalized for Any Reason | Y N Rheumatic Fever | Y N Ulcers |
| Y N Chicken Pox | Y N Hay Fever | | Y N Scarlet Fever | Y N Venereal Disease |

Please list any serious medical condition(s) that you have experienced _____

AUTHORIZATIONS

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. My method of payment will be _____

Signature _____ Date _____

PAYMENT IS DUE AT TIME OF SERVICE

I certify that I am covered by _____ Insurance Co. and I assign directly to Dr. Fellows all insurance benefits, otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature _____ Date _____