Welcome to Elmwood Family Dental Date_____

Name_____ Home Phone (_____)_____
Last First Middle
Address_____ Work Phone (_____)_____

City_____ State_____ Zip Code_____ Cell (_____)_____

Occupation_____ Social Security No._____

Date of Birth:___/___/___ Gender: M F Height:_____ Weight:_____ Single____ Married____ Divorced____ Widowed____

Emergency Contact/Relaitionship_____ Phone (_____)_____

If you are completing this form for another person, what is your relationship to that person? _____

Referred by _____

For the following questions, *circle yes or no*, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

1. Are you in good health?..... Yes No

2. Has there been any change in your general health within the past year?.....Yes No

3. My last physical examination was on _____

4. Are you now under the care of a physician?.....Yes No
   If so, what is the condition being treated?_____

5. The name and address of my physician(s) is _____

   _____

   _____Phone (_____)_____

6. Have you had any serious illness, operation, or been hospitalized in the past 5 years?..... Yes No
   If so, what was the illness or problem?_____

7. Are you taking any medication including non-prescription medication?.....Yes No
   If so, what are you taking?_____

8. Have you ever taken Fosamax, Boniva, or any other drugs prescribed to decrease resorption of bone (osteoporosis)?...Yes No

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

AIDS	❑	Yes	❑	No	Fainting or dizziness	❑	Yes	❑	No	Pacemaker	❑	Yes	❑	No
Anemia	❑	Yes	❑	No	Glaucoma	❑	Yes	❑	No	Psychiatric Care	❑	Yes	❑	No
Arthritis, Rheumatism	❑	Yes	❑	No	Headaches/Migraines	❑	Yes	❑	No	Radiation Treatment	❑	Yes	❑	No
Artificial Heart Valve	❑	Yes	❑	No	Heart Murmur	❑	Yes	❑	No	Respiratory Disease	❑	Yes	❑	No
Artificial Joints	❑	Yes	❑	No	Heart Problems	❑	Yes	❑	No	Rheumatic Fever	❑	Yes	❑	No
Asthma	❑	Yes	❑	No	Herpes	❑	Yes	❑	No	Scarlet Fever	❑	Yes	❑	No
Back Problems	❑	Yes	❑	No	Hepatitis	❑	Yes	❑	No	Shortness of Breath	❑	Yes	❑	No
Bleeding Disorders	❑	Yes	❑	No	type_____					Sinus Trouble	❑	Yes	❑	No
Blood Disease	❑	Yes	❑	No	HIV Positive	❑	Yes	❑	No	Skin Rash/Shingles	❑	Yes	❑	No
Blood Transfusion	❑	Yes	❑	No	High Blood Pressure	❑	Yes	❑	No	Special Diet	❑	Yes	❑	No
Cancer	❑	Yes	❑	No	Jaw Pain	❑	Yes	❑	No	Swelling of Feet or				
Chemical Dependency	❑	Yes	❑	No	Jaundice	❑	Yes	❑	No	Ankles	❑	Yes	❑	No
Chemotherapy	❑	Yes	❑	No	Kidney Disease	❑	Yes	❑	No	Swollen Neck Glands	❑	Yes	❑	No
Circulatory Problems	❑	Yes	❑	No	Liver Disease	❑	Yes	❑	No	Thyroid Problems	❑	Yes	❑	No
Congenital Heart					Low Blood Pressure	❑	Yes	❑	No	Tonsillitis	❑	Yes	❑	No
lesions	❑	Yes	❑	No	Mitral Valve Prolapse	❑	Yes	❑	No	Tobacco Habit	❑	Yes	❑	No
Cortisone Treatments	❑	Yes	❑	No	Nervous Disorder	❑	Yes	❑	No	type_____				
Cough, persistent or					Osteoporosis	❑	Yes	❑	No	Tuberculosis	❑	Yes	❑	No
bloody	❑	Yes	❑	No	Women:					Tumor or growth on				
Diabetes	❑	Yes	❑	No	Are you pregnant?	❑	Yes	❑	No	head or neck	❑	Yes	❑	No
Emphysema	❑	Yes	❑	No	Due date_____					Ulcer	❑	Yes	❑	No
Do you wear					Are you nursing?	❑	Yes	❑	No	Venereal Disease	❑	Yes	❑	No
contact lenses?	❑	Yes	❑	No	Taking birth control					Weight loss	❑	Yes	❑	No
Epilepsy	❑	Yes	❑	No	pills?	❑	Yes	❑	No	(unexplained)				

Do you have any disease, condition, or problem not listed that the dentist should know about?_____
_____

Check (√) if you are allergic to any of the following:

- ❑ Aspirin
- ❑ Barbiturates (sedatives)
- ❑ Codeine (or other narcotics)
- ❑ Iodine
- ❑ Latex
- ❑ Local Anesthetics
- ❑ Jewelry/metals
- ❑ Penicillin
- ❑ Sulfa Drugs
- ❑ Tetracycline
- ❑ Erythromycin
- ❑ Other_____

Reason for Today's Visit:_____

Former Dentist:_____Address:_____

Date of last dental cleaning:_____Date of last dental treatment:_____Date of last dental x-rays:_____

Reason for leaving previous Dentist:_____

Check (√) if you have had problems with any of the following:

- ❑ Bad Breath
- ❑ Bleeding Gums
- ❑ Clicking or popping jaw
- ❑ Complications following dental tx
- ❑ Food collection between teeth
- ❑ Grinding teeth
- ❑ Loose teeth or broken fillings
- ❑ Periodontal treatment
- ❑ Sensitivity to cold
- ❑ Sensitivity to hot
- ❑ Sensitivity to sweets
- ❑ Sensitivity when biting
- ❑ Sleep apnea
- ❑ Snoring
- ❑ Sores or growths in your mouth

Have you ever been told that you need to "pre-medicate" before dental work? ❑ Yes ❑ No

Have you ever had orthodontics (braces)? ❑ Yes ❑ No
If so, as a child_____ or adult_____

Have you ever seen a periodontist (gum specialist)? ❑ Yes ❑ No

How often do you brush your teeth?_____times per day

How often do you floss?_____times per week

Are you happy with your smile? ❑ Yes ❑ No

Is there anything that you would like to discuss with the dentist in private? ❑ Yes ❑ No

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Payment is due in full at the time of treatment
unless prior arrangements have been approved

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I also understand that I am responsible for paying any co-payments and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that the responsibility for the payment of dental services is mine and not my insurance company's. A 1½% per month finance charge will be added to all accounts over 60 days (18% annually).

Signature_____Date_____

Authorization to Release Information:

I hereby authorize "Elmwood Family Dental" to provide any insurance company(ies) claim administrator(s), and consulting health care professionals, information concerning health care, advice, treatment, or supplies provided. This information will be used exclusively for the purpose of evaluating and administering claims for benefits.

Signature_____Date_____
