GRAHAM
FAMILY DENTAL CARE

# WELCOME

## About You

Today's Date: _____ E-Mail Address: _____

Name: _____ Preferred Name: _____
Last First MI

Birthdate: ___/___/___ Age: ___ ☐ Male ☐ Female ☐ Other: _____ SSN#: _____ DL#: _____

Home Address: _____
Street City State Zip

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Cell #: (___) _____ Work #: (___) _____ Home Phone #: (___) _____

Whom may we thank for referring you? _____ Other family members seen by us? _____

Employer: _____ Occupation: _____

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

**Emergency Contact:**

**Name:** _____ **Relationship:** _____ **Phone #:** (___) _____

## Dental Insurance Information

**Dental Coverage?** ☐ Y ☐ N

**Primary Dental Insurance**

Insurance Co. Name: _____ Phone #: (___) _____ Group #: _____

Insurance Co. Address: _____

Insured's Name: _____ Relation: _____ Birthdate: ___/___/___

Insured's Employer: _____

**Secondary Dental Insurance**

Insurance Co. Name: _____ Phone #: (___) _____ Group #: _____

Insurance Co. Address: _____

Insured's Name: _____ Relation: _____ Birthdate: ___/___/___

Insured's Employer: _____

## Responsible Party or Insurance Policy Holder

Their Name: _____ Birthdate: ___/___/___ SS#: _____

Employer: _____ Phone #: (___) _____ Relationship to responsible party: _____

Billing Address: _____

# Dental History

What concerns brought you to our office today?

_____

Are you currently in pain? ☐ Y ☐ N

Previous / Current Dentist? _____

Last visit date? _____ Last cleaning? _____

Have you ever experienced problems associated with any previous dental work? _____

Have you been instructed to routinely take antibiotics prior to dental appointments? ☐ Y ☐ N

Do you now or have you ever experienced pain / discomfort with your jaw joint (TMJ / TMD)? ☐ Y ☐ N

Your current dental health is:

☐ Good ☐ Fair ☐ Poor ☐ Unknown

How many times a day do you brush? _____

How many times a week do you floss? _____

How often do you replace your toothbrush?

_____

Do your gums ever bleed? ☐ Y ☐ N

Are your teeth sensitive to heat/cold? _____

Do you like your smile? ☐ Y ☐ N

If no, please explain: _____

# Medical History

Do you have a personal physician? ☐ Y ☐ N Date of last visit? _____ Physician's Name: _____

Physician's Address: _____ Physician's Phone #: (___) _____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor ☐ Unknown

Do you smoke or use tobacco in any form? ☐ Y ☐ N

Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath? ☐ Y ☐ N

Have you ever taken Fosamax or any other Bisphosphonate? ☐ Y ☐ N

**For Women:** Are you pregnant? ☐ Unsure ☐ Yes ☐ No Week #: _____

Are you Nursing? ☐ Yes ☐ No Are you taking birth control pills? ☐ Yes ☐ No

Are you allergic to penicillin? ☐ Y ☐ N

Please list any other drug / material allergies: _____

**Have you ever had any of the following diseases or medical problems?** Check here if none apply ☐

| | | |
|---|---|---|
| ☐ Acid Reflux / GERD | ☐ Glaucoma | ☐ Lupus |
| ☐ AIDS / HIV Positive | ☐ Hay Fever / Seasonal Allergies | ☐ Mitral Valve Prolapse |
| ☐ Alzheimer's Disease | ☐ Headaches / Migraines | ☐ Osteoporosis |
| ☐ Arthritis | ☐ Heart Attack | ☐ Psychiatric Care |
| ☐ Artificial Heart Valve | ☐ Heart Murmur | ☐ Rheumatic / Scarlet Fever |
| ☐ Artificial Joint | ☐ Heart Surgery / Pacemaker | ☐ Shingles |
| ☐ Asthma | ☐ Hemophilia | ☐ Sinus Trouble |
| ☐ Breathing Problems (Emphysema/COPD/Etc) | ☐ Hepatitis ( A / B / C ? ) | ☐ Sleep Apnea |
| ☐ Cancer - Type: _____ | ☐ Herpes | ☐ Stroke |
| Radiation: ____ Chemo: ____ | ☐ High Blood Pressure | ☐ Thyroid Disease |
| ☐ Congenital Heart Disease | ☐ High Cholesterol | ☐ Tuberculosis |
| ☐ Diabetes ( Type 1 or 2 ? ) A1C: ____ | ☐ Kidney Problems | ☐ Ulcers / Colitis |
| ☐ Drug / Alcohol Abuse | ☐ Liver Problems | |
| ☐ Epilepsy / Seizures | ☐ Low Blood Pressure | |

Please list any other illness or medical condition not included above, or elaborate on above conditions as necessary:

_____

_____

List any medications currently taking and what for: _____

_____

_____

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.

_____

SIGNATURE DATE

**Payment is due at the time of service.** If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to this office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize any release of information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

_____

SIGNATURE DATE