Personal Information

Name_____
I prefer to be called_____
Single _____Married_____
Male_____ Female _____
Birth date _____
Social security # _____
Home address _____
_____
Home phone _____
Work phone _____
Cell phone _____
Email address _____
How do you prefer to be confirmed?
Home phone Cell phone Email

Other family members seen by us
_____
Referred by _____

Person responsible for account _____
Relationship_____
Social security #_____
Home phone_____
Work phone_____
Billing address_____

Are you currently under the care of a physician? _____
Physician's name_____
Physician's phone # _____
Are you currently taking any prescription or over the counter drugs?
Please list _____
Do you smoke or use tobacco in any form? Yes_____ No_____

For women only: Are you pregnant? _____ Nursing_____
Are you taking birth control pills? Yes_____ No _____

Insurance Information

Primary:
Dental coverage: Yes_____ No_____
Insurance Co. name _____
Insurance Co. address _____
_____
Insurance Co. phone #_____
Group # _____
Insured's name _____
Relationship _____
Insured's date of birth _____
Insured's social security #_____
Insured's employer _____

Secondary:
Dental coverage**: Yes_____ No_____**
Insurance Co. name_____
Insurance Co. address_____
_____
Insurance Co. phone #_____
Group #_____
Insured's name _____
Relationship _____
Insured's date of birth_____
Insured's social security #_____
Insured's employer _____

NESCONSET DENTAL ASSOCIATES

- Dental History -

Previous dentist _____ Last date of checkup or cleaning_____
Do you require antibiotics before dental treatment? Yes _____ No_____
Do you have discomfort in your jaw joint? (TMJ / TMD) Yes _____ No _____
Do your gums ever bleed? Yes_____ No _____
Why have you come to the dentist today? _____
Are you happy with your smile? _____
Please circle the most important feature(s) in your smile that you would like to change.
Color Shape Alignment Length Gaps Gum display Other_____

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

___Yes	**___ No**	Abnormal Bleeding	**___Yes**	**___ No**	Hemophilia
___Yes	**___ No**	Alcohol / Drug abuse	**___Yes**	**___ No**	Hepatitis A, B, C
___Yes	**___ No**	Anemia	**___Yes**	**___ No**	Herpes / Fever blisters
___Yes	**___No**	Arthritis	**___Yes**	**___ No**	High Blood pressure
___Yes	**___No**	Artificial joints	**___Yes**	**___ No**	HIV+ / AIDS
___Yes	**___No**	Artificial heart valve	**___Yes**	**___ No**	Kidney problems
___Yes	**___No**	Asthma	**___Yes**	**___ No**	Liver disease
___Yes	**___No**	Blood transfusion	**___Yes**	**___ No**	Low blood pressure
___Yes	**___No**	Cancer / Chemotherapy	**___Yes**	**___ No**	Mitral valve prolapse
___Yes	**___No**	Colitis	**___Yes**	**___ No**	Pacemaker
___Yes	**___No**	Congenital Heart Defect	**___Yes**	**___ No**	Psychiatric problems
___Yes	**___No**	Diabetes	**___Yes**	**___ No**	Radiation treatment
___Yes	**___No**	Difficulty breathing	**___Yes**	**___ No**	Rheumatic / Scarlet fever
___Yes	**___No**	Emphysema	**___Yes**	**___ No**	Seizures
___Yes	**___No**	Epilepsy	**___Yes**	**___ No**	Shingles
___Yes	**___No**	Fainting spells	**___Yes**	**___ No**	Sickle cell disease / traits
___Yes	**___No**	Frequent headaches	**___Yes**	**___ No**	Sinus problems
___Yes	**___No**	Glaucoma	**___Yes**	**___No**	Stroke
___Yes	**___No**	Hay Fever	**___Yes**	**___No**	Thyroid problem
___Yes	**___No**	Heart Murmur	**___Yes**	**___No**	Tuberculosis (TB)
___Yes	**___No**	Heart Attack	**___Yes**	**___No**	Ulcers
___Yes	**___No**	Heart Surgery	**___Yes**	**___No**	Venereal disease

Have you been hospitalized for any reason? _____
Please list any other serious medical conditions that you have ever had.
_____

Are you allergic to any of the following?

___Yes	___No	Aspirin	___Yes	___No	Erythromycin	___Yes	___No	Metals
___Yes	___No	Codeine	___Yes	___No	Jewelry	___Yes	___No	Penicillin
___Yes	___No	Dental anesthetics	___Yes	___No	Latex	___Yes	___No	Tetracycline

Please list any other drugs/ materials that you might be allergic to.
_____

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 responsible to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

Signature Print name Date