WELCOME TO ARBOR DENTAL

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

Patient Name Last _____ First _____ Middle Initial _____ Mr Mrs Ms Dr

I prefer to be called _____ Male__ Female __ Birthdate _____ Age _____ Social Security # _____

Home Address _____ City _____ State _____ Zip _____

Single __ Married __ Divorced __ Widowed __ Separated __ Home #_____ Work # _____ Cell #_____

Employer _____ Occupation _____

Last Dental Visit _____ Whom may we thank for referring you to our office?_____

PERSON RESPONSIBLE FOR ACCOUNT

Name Last _____ First _____ Middle Initial _____

Home Address _____ City _____ State _____ Zip _____

Birth Date _____ Home Phone _____ Work Phone _____ Cell Phone: _____

Social Security # _____ D L # _____ Relationship to Patient _____

Employer _____ Occupation _____

SPOUSE INFORMATION

Name _____ Birth Date _____ Social Security #_____

Work Phone _____ Employer _____ Occupation _____

EMERGENCY INFORMATION-RELATIVE NOT LIVING WITH YOU

Name _____ Address _____ Phone _____

DENTAL INSURANCE (PRIMARY CARRIER) SECONDARY (complete if you have dual insurance coverage)

Insurance Co. _____ Insurance Co. _____

Insured's Name _____ Insured's Name _____

Insured's Employer _____ Insured's Employer _____

Insured's Social Security # _____ Insured's Social Security #_____

Group # _____ Local # _____ Group # _____ Local # _____

MEDICAL HISTORY

We need to know about your Medical & Dental History, this information is confidential.

Do you have a personal physician? Yes __ No __ Physician's Name _____Phone _____

Are you currently under the care of a physician? Yes __ No __ Please explain _____

Your current physical health is: Good __ Fair __ Poor __ Last Exam _____

Have you ever taken Fosamax, or any other bisphosphonate? Yes __ No __ Have you ever taken Phen-fen? Yes __ No __

Are you taking any prescription/over-the-counter or herbal supplement drugs? Yes __ No __

Please list each one: _____

_____

For Women:

Are you pregnant? Yes __ No __ Are you nursing? Yes __ No __ Are you using a prescribed method of birth control? Yes __ No __

MEDICAL HISTORY *continued*

Have you ever had any of the following diseases or medical problems? *Please mark yes or no for each:*

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

Please list any serious medical condition(s) that you have ever had: _____

_____

Are you allergic to any of the following? *Please mark yes or no for each:*

Y N	Aspirin	Y N	Erythromycin	Y N	Metals
Y N	Codeine	Y N	Jewelry	Y N	Penicillin
Y N	Dental Anesthetics	Y N	Latex	Y N	Tetracycline

Please list any other drugs / materials that you are allergic to: _____

DENTAL HISTORY

What brought you to the dentist today? _____

Do you require antibiotics before dental treatment? Yes __ No __ Are you currently in pain? Yes __ No __ Do your gums ever bleed? Yes __ No __

Have you ever had a serious / difficult problem 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 like your smile? Yes __ No __ Explain: _____

Would you like whiter teeth? Yes __ No __ Fresher breath? Yes __ No __ Type of bristles? Soft __ Medium __ Hard __

How many times a week do you floss? _____ a day do you brush? _____

Do you smoke or use tobacco in any other form? Yes __ No __ Previous Dentist _____

SIGNATURE

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 change 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. 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.

Signature _____Date_____

OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein. Initials: _____ Date: _____

Doctor's Comments: _____