

Welcome

On behalf of Dr. Brian R. Adams and our Dental Team, we are pleased to welcome you to the practice.

Please take a few minutes to fill out this form as completely as you can. If you have questions we will be glad to help you.

All information will be kept confidential.

Patient Information

Patient's Name: _____ Email: _____

I prefer to be called _____

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

Social Security # _____ - _____ - _____ Birthdate: ___ / ___ / ___ Age: _____ Sex _____

Marital Status: Single Married Divorced/Separated Widowed

Address: _____ City: _____ Zip: _____

Patients Employer: _____ Occupation: _____

Spouse's Name: _____ Spouse's Employer: _____

Person to contact in case of an emergency: _____ Phone: () _____

Is the patient a student? Full Time Part Time School: _____

Responsible Party's Information

Person Responsible for Account: _____ Relation to Patient _____

Home Phone: () _____ Work Phone: () _____

Mailing Address: _____ City: _____ Zip: _____

Social Security #: _____ - _____ - _____ Drivers License #: _____

Employer: _____ Occupation: _____

Employer's Address: _____ City: _____ Zip: _____

Have you or any member of your family been a patient at this office before? YES NO

If YES, Name: _____

Primary Dental Insurance: YES NO

Secondary Dental Insurance: YES NO

Insured's Name: _____

Insured's Name: _____

SS #: _____ - _____ - _____ DOB: ___ / ___ / ___

SS #: _____ - _____ - _____ DOB: ___ / ___ / ___

Employer: _____

Employer: _____

Insurance Company/Plan: _____

Insurance Company/Plan: _____

Union/ Group Name: _____

Union/ Group Name: _____

Group or Policy #: _____ Local#: _____

Group or Policy #: _____ Local#: _____

Date Employed: _____

Date Employed: _____

Who may we thank for recommending our office to you? _____

Otherwise, how did you choose our practice? Insurance plan Yellow pages Mailer/AD

Other source: _____

Patient's Dental History

What is the primary reason for your Dental visit? _____

Are you aware of any Dental problems? If so, please explain: _____

Name of your previous Dentist: _____

Date of last Dental Exam/Cleaning: _____ Date of last X-rays: _____

Did your last Dentist recommend any dental treatment for you? If so please describe: _____

Have you had any complications with dental procedures in the past? _____

Please Indicate Past Dental Treatments:

- Root Canal Therapy? YES NO
- Extractions/Oral surgery? YES NO
- Orthodontics (braces)? YES NO
- Gum Surgery/ Deep Cleaning? YES NO
- Dental Implants? YES NO
- Treatment for TMJ? YES NO

Are you currently experiencing any of the following?

- TMJ/ Jaw Pain? YES NO
- Bleeding/Swollen gums? YES NO
- Grinding/Clenching teeth? YES NO
- Bad Breath? YES NO
- Sensitivity to Sweets/Hot/Cold? YES NO
- Pain when Chewing? YES NO

Are you interested in Cosmetically Improving your Smile? If so please explain: _____

Are you interested in Dental Whitening? YES NO

Patient's Medical History

Name of your Physician: _____ Phone #: _____

Date of your last Medical Exam: _____ Findings: _____

Are you currently undergoing any Medical Treatment? _____

Have you been Hospitalized within the past 5 years? If so, for what reason? _____

List all Medications that you currently take:

Medication	Reason
_____	_____
_____	_____

If you have Allergies to any Medications, please list them: _____

Indicate all conditions that pertain to the patient:

- | | | | |
|--|--|---------------------------------------|--|
| Heart Disease | <input type="checkbox"/> YES <input type="checkbox"/> NO | Do you drink Alcohol? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Heart Murmur | <input type="checkbox"/> YES <input type="checkbox"/> NO | If Yes, how much? _____ | |
| Mitral Valve Prolapse | <input type="checkbox"/> YES <input type="checkbox"/> NO | Allergies to Penicillin/Antibiotics | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Artificial Heart Valve | <input type="checkbox"/> YES <input type="checkbox"/> NO | Allergies to Local Anesthesia | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Rheumatic/Scarlet Fever | <input type="checkbox"/> YES <input type="checkbox"/> NO | Latex allergy or Sensitivity | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Pace maker | <input type="checkbox"/> YES <input type="checkbox"/> NO | Abnormal Bruising/ Bleeding | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| High or Low Blood Pressure | <input type="checkbox"/> YES <input type="checkbox"/> NO | Anemia | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Chest pain | <input type="checkbox"/> YES <input type="checkbox"/> NO | Blood Transfusions | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Stroke | <input type="checkbox"/> YES <input type="checkbox"/> NO | Hemophilia/ Blood Diseases | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Fainting or Dizziness | <input type="checkbox"/> YES <input type="checkbox"/> NO | Liver or Kidney Disease | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Shortness of Breath | <input type="checkbox"/> YES <input type="checkbox"/> NO | Diabetes | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Artificial Joints | <input type="checkbox"/> YES <input type="checkbox"/> NO | Hepatitis A, B, C | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Head or Neck Radiation | <input type="checkbox"/> YES <input type="checkbox"/> NO | Ulcers or Digestive Problems | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Chemotherapy | <input type="checkbox"/> YES <input type="checkbox"/> NO | Seizures or Epilepsy | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| HIV/AIDS | <input type="checkbox"/> YES <input type="checkbox"/> NO | Asthma/Emphysema/Respiratory Problems | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Cold Sores/ Fever Blisters | <input type="checkbox"/> YES <input type="checkbox"/> NO | Phen-Fen, Pondimin, or Redux | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Sinus Problems | <input type="checkbox"/> YES <input type="checkbox"/> NO | Tuberculosis | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Are you currently Pregnant? | <input type="checkbox"/> YES <input type="checkbox"/> NO | Arthritis/ Rheumatism | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| If Yes, how many months? _____ | | Thyroid Disease | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Do you use Tobacco? | <input type="checkbox"/> YES <input type="checkbox"/> NO | | |
| If Yes, what type and frequency? _____ | | | |

All of the information given is accurate to the best of my knowledge. I understand that it is my responsibility to inform Dr. Brian R. Adams of any changes in my Health. Signature: _____ Date: _____

Reviewed by: _____