ELGIN DENTAL CARE

1 About You

Today's Date: _____

E-mail Address: _____

Last Name: _____

First Name: _____ MI: _____ Mr Mrs Ms Dr

I prefer to be called: _____ ☐ Male ☐ Female

Birthdate: _____/_____/_____ Age: _____

SS#: _____

Home Address: _____

_____
CITY STATE ZIP

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm #: (_____)_____ Cell #: (_____)_____

Wk #: (_____)_____ Ext. _____ DL #: _____

Employer: _____

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we Thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____
(Please Circle)

Last Visit Date: _____

2 Spouse Information

His / Her Name: _____

Employer: _____

Cell #: (_____)_____ SS #: _____

Birthdate: ____/____/____ Driver's License#: _____

Person Responsible for Account: _____

Cell #: (_____)_____ Hm #: (_____)_____

Billing Address: _____

Relation: _____ SS #: _____

Employer: _____ DL #: _____

3 Insurance Coverage

Primary

Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Phone #: (_____)_____

Insured's Name: _____

Insured's Birthday: _____/_____/_____

Insured's SS #: _____

Secondary

Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Phone #: (_____)_____

Insured's Name: _____

Insured's Birthday: _____/_____/_____

Insured's SS #: _____

In the event of an emergency, is there someone who lives near you that we should contact?

His / Her Name: _____

Relation: _____

Cell #: (_____)_____ Hm #: (_____)_____

4 Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Phone #: (_____)_____ Date of last visit: _____

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

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580-492-5200

4 Medical History *Continued*

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

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

Please list each one:

_____

_____

_____

Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

Have you ever taken Phen-fen? ☐ Yes ☐ No

For Women: Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #:_____

Are you nursing? ☐ Yes ☐ No

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

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

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

_____

_____

Are you allergic to any of the following?

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: _____

_____

5 Dental History

Why have you come 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

Would you like whiter teeth? ☐ Yes ☐ No Fresher breath? ☐ Yes ☐ No

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

Type of bristles? ☐ Soft ☐ Medium ☐ Hard

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

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 authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

Signature Date

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

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

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA..

OFFICE USE ONLY • OFFICE USE ONLY • OFFICE USE ONLY • OFFICE USE ONLY

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