Welcome to
Family Dental Care

Our Goal is to give you a happy, healthy smile. Please fill out this form completely so we can accomplish this goal together.

About You:	**Primary Insurance:**
Today's Date:	Dental Coverage: Yes No
First Name: Middle Initial:	Insurance Company:
Last Name:	Insurance Company Address:
I prefer to be called:	City: State: Zip Code:
☐Male ☐Female Birthdate : / /	Insurance Company Phone Number:
Age: Social Security Number:	Member ID: Group #:
Home Address:	Insured Subscriber Name: Relation: Birthdate: / /
City: State: Zip Code:	Insured's Social Security Number:
Home Phone:	Insured's Employer:
Cell Phone:	Employer Address:
Work Phone:	City: State: Zip Code:
Email Address:	**Secondary Insurance:**
Marital Status:	Dental Coverage: Yes No
Employer:	Insurance Company:
Employer's Address:	Insurance Company Address:
Occupation: How long there ?	City: State: Zip Code:
Whom may we thank for referring you ?	Insurance Company Phone Number:
Other family members seen by us:	Member ID: Group #:
Previous Dentist:	Insured Subscriber Name: Relation: Birthdate: / /
Date of last cleaning and exam:	Insured's Social Security Number:
Person responsible for account:	Insured's Employer:
Emergency contact:	Employer Address:
Relation:	City: State: Zip Code:
Contact's Phone Number:	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. I hereby authorize payment directly to Family Dental Care of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered to my insurance company. Signature:_____ Date: / /
Spouse's Name:	
Spouse's Phone Number:	

Medical History

Physician's Name:

Phone: Date of Last visit: / /

Are you currently under the care of a physician? Y N

Please Explain:

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

Have you had any mental rods, pins or implants? Y N

Are you taking any prescription/over-the- counter drugs? Y N
Please List:

Have you ever taken Phen-Fen(aka Redux or Pondimin)? Y N
If so, When?

Have you ever taken Fosamax,or any other biphosphonate? Y N

For Women Only

Are you pregnant? Y N How many weeks?

Are you nursing? Y N

Any Additional Info to add:

Are you allergic to any of the following?

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

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

Your Smile Evaluation

Why Have you come to the dentist today?

Are you currently in pain? Y N

Do you require antibiotics before dental treatment? Y N

Have you ever had gum treatment? Y N

Do your gums bleed? Y N

Have you ever had periodontal disease? Y N

Do you ever experience discomfort in your jaw ? Y N

Are your teeth sensitive to heat, cold, or anything else? Y N

Are you happy with the way your smile looks? Y N

Would you like whiter teeth? Y N Straighter Teeth? Y N

If you could change one thing about your teeth and/or smile what would it be?

The most important thing to you regarding your dental health is?

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

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

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

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 to any changes in my medical status. I authorize the Family Dental Care Staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

Signature_____ Date / /