ASARODENTAL

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Welcome

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

1 ABOUT YOU

Today's Date: _____

Email Address: _____

Name: _____
Last First Mi Mr Mrs Ms Dr

I prefer to be called: _____ ◯ Male ◯ Female

Birthdate: _____ Age: _____ SS#: _____

Home Address: _____
Apt/Condo#

_____
City State Zip

◯ Single ◯ Married ◯ Divorced ◯ Widowed ◯ Separated

Hm #: _____ Page / Cell#: _____

Wk #: _____ Ext: _____ DL #: _____

Employer: _____

Employer's Address: _____

_____
City State Zip

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Who may we thank for referring you? _____

Other family members seen by us: _____

◯ Previous ◯ Present Dentist: _____

Last Visit Date: _____

2 SPOUSE INFORMATION

His / Her Name: _____

Employer: _____

Wk #: _____ Ext: _____ SS#: _____

Birthdate: _____ DL #: _____

Person responsible for account: _____

Wk #: _____ Ext: _____ Hm #: _____

Billing Address: _____

Relationship: _____ SS#: _____

Employer: _____ DL #: _____

3 INSURANCE

Primary Insurance

Dental Coverage? ◯ Yes ◯ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: _____ Insured's ID#: _____

Insured's Employer: _____

Insured's Address: _____

Secondary Insurance

Dental Coverage? ◯ Yes ◯ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: _____ Insured's ID#: _____

Insured's Employer: _____

Insured's Address: _____

Neighbor or relative not living with you

His / Her Name: _____ Relation: _____

Wk#: _____ Hm#: _____

Address: _____

_____
City State Zip

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: _____

CONTINUED ON BACK...

4 MEDICAL HISTORY *continued*

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

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

Have you had any metal rods, pins or implants? ○ Yes ○ No

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

Please list each one: _____

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

Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath? ○ 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?

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

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

_____

Are you allergic to any of the following?

- ☐ Aspirin
- ☐ Codeine
- ☐ Dental Anesthetics
- ☐ Erythromycin
- ☐ Latex
- ☐ Penicillin
- ☐ Tetracycline
- ☐ Other

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

Have you ever had a serious / difficult problem associated with any previous dental work? ○ Yes ○ No

Do you have fears about going to the dentist? ○ Yes ○ No

Have you ever had gum treatment? ○ 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? ○ Y ○ N Do your gums ever bleed? ○ Y ○ N

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

Type of bristles? ○ Soft ○ Medium ○ Hard

How long do you use a toothbrush before replacing it?

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

Have you lost any teeth? ○ Yes ○ No If yes, why? _____

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 have received a copy of this office's Notice of Privacy Practices.

_____

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. I hereby authorize payment directly to the Dental Office 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

Our office is HIPPA Compliant and is 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 OFFICE USE ONLY

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

Doctor's Comments: _____

_____

I have read my medical history dated _____ and confirmed that it states past and present medical conditions.

_____

Signature Date

I have read my medical history dated _____ and confirmed that it states past and present medical conditions.

_____

Signature Date

I have read my medical history dated _____ and confirmed that it states past and present medical conditions.

_____

Signature Date