Welcome To Our Practice

ABOUT YOU

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

Name: _____ I prefer to be called: _____ M __ F__
Last First MI Mr. Mrs. Ms. Dr.

Birthdate: ___/ ___/ ___ Age:____ Soc. Sec #_____ Single ___ Married ___ Divorced ___ Widowed ___ Separated ___

Home Address: _____
Street City State Zip

Home Ph: (___)_____ Work: (___)_____ Ext: _____ Cell: (___)_____ Driver's Lic #_____

Where & when are the best times to reach you? _____ May we call you at work: Y__ N__

Other family members seen by us: _____

Whom may we thank for referring you? _____ Relationship: _____

Employer: _____ How long? _____ Occupation: _____

Employer's Address: _____
Street City State Zip

Emergency Contact: _____ Relation: _____ Home Phone: (___)_____ Other: (___)_____

SPOUSE INFORMATION

His / Her Name:_____ Birthdate: ___/ ___/ ___ Soc. Sec #_____

Employer: _____ Work Ph: (___)_____ Ext: _____ Cell: (___)_____

INSURANCE INFORMATION

Primary Insurance Dental Coverage: Y__ N__ Medical Coverage: Y__ N__ Orthodontic Coverage: Y__ N__

Insurance Co. Name: _____ Phone: (___)_____ Group # (Plan or Policy #): _____

Insurance Co. Address: _____
Street / PO Box City State Zip

Insured's Name: _____ Insured's Soc. Sec #_____ Birthdate: ___/ ___/ ___ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street / PO Box City State Zip

Secondary Insurance Dental Coverage: Y__ N__ Medical Coverage: Y__ N__ Orthodontic Coverage: Y__ N__

Insurance Co. Name: _____ Phone: (___)_____ Group # (Plan or Policy #): _____

Insurance Co. Address: _____
Street / PO Box City State Zip

Insured's Name: _____ Insured's Soc. Sec #_____ Birthdate: ___/ ___/ ___ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street / PO Box City State Zip

Authorization of benefits: I certify that I am covered by the insurance noted above and I assign directly to Dr. George Mighion all insurance benefits, otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature: _____ Date: _____

DENTAL HISTORY

Why have you come to the dentist today?_____

_____

Are you currently in pain? Yes ___ No ___

Do you require antibiotics before dental treatment? Yes ___ No ___

Have you experienced problems 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 floss daily? Yes ___ No ___ Brush daily? Yes ___ No ___

Type of bristles on your toothbrush? Hard ___ Medium ___ Soft ___

How long do you use a toothbrush before replacing it? _____

Do you use anything in addition to your brush and floss? Yes ___ No ___

If yes, what? _____

Would you like fresher breath? Yes ___ No ___

Do you wish your teeth were whiter? Yes ___ No ___

Do your gums ever bleed or feel irritated? Yes ___ No ___

Have you ever had periodontal disease? Yes ___ No ___

Do you have mobility in your teeth? Yes ___ No ___

Are your teeth sensitive to heat, cold, or anything else? Yes ___ No ___

Do you still have your wisdom teeth? Yes ___ No ___

Previous Dentist: _____ Last Visit Date: _____

Why did you leave your last dentist? _____

_____

What did you like least & most about any dentist you have seen? _____

_____

Are you happy with the way your smile looks? Yes ___ No ___

If not, what would you change? _____

_____

_____

MEDICAL HISTORY

Physician's Name: _____

Address: _____

Street City State Zip

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

Your current physical health is? Good ___ Fair ___ Poor ___

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

If yes, explain: _____

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

Are you allergic to any of the following? (Please X any that apply)

___ Aspirin ___ Erythromycin ___ Sedatives
___ Barbiturates ___ Jewelry / Metals ___ Sulfa Drugs
___ Codeine ___ Latex ___ Tetracycline
___ Dental Anesthetics ___ Penicillin ___ Other

Please list all additional drugs / materials that cause allergic reactions:

_____

For Women: Are you taking birth control pills? Yes ___ No ___

Are you pregnant? Unsure ___ Yes ___ No ___ Weeks: _____

Are you nursing? Yes ___ No ___

Are you taking any of the following?

___ Acetaminophen ___ Blood Thinners ___ Insulin / Diabetes Drugs ___ Thyroid Medicine
___ Antibiotics ___ Blood Pressure Medication ___ Nitroglycerin ___ Tranquilizers
___ Antihistamines ___ Cold Remedies ___ Recreational Drugs
___ Aspirin ___ Digitalis / Heart Medication ___ Steroids / Cortisone

Have you ever taken Phen-Fen? Also known as Redux or Pandimin. Yes ___ No ___

Are you taking any prescription, over-the-counter drugs, herbal remedies, vitamins or minerals not listed above? Yes ___ No ___ If yes, please list each one:

_____

Do you or have you experienced the following?

___ Abnormal Bleeding ___ Colitis ___ Headaches ___ Liver Disease ___ Seizures
___ Alcohol Abuse ___ Congenital Heart Disease ___ Heart Attack ___ Low Blood Pressure ___ Shingles
___ Anemia ___ Diabetes ___ Heart Murmur ___ Lupus ___ Sickle Cell Disease
___ Arthritis ___ Difficulty Breathing ___ Heart Surgery ___ Mitral Valve Prolapse ___ Sinus Problems
___ Artificial Bones / Joints ___ Drug Abuse ___ Hemophilia ___ Osteoporosis / Paget's Disease ___ Steroid Therapy
___ Artificial Valves ___ Emphysema ___ Hepatitis ___ Pacemaker ___ Stroke
___ Asthma ___ Epilepsy ___ Herpes ___ Persistent Cough ___ Thyroid Problems
___ Blood Transfusion ___ Fainting Spells ___ High Blood Pressure ___ Psychiatric Problems ___ Tonsillitis
___ Cancer ___ Fever Blisters ___ HIV+ / AIDS ___ Radiation Treatment ___ Tuberculosis (TB)
___ Chemotherapy ___ Glaucoma ___ Hospitalization ___ Rheumatic Fever ___ Ulcers
___ Chicken Pox ___ Hay Fever ___ Kidney Problems ___ Scarlet Fever ___ Venereal Disease

Please list any serious medical condition(s) you have experienced: _____

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in medical status. I authorize the dental staff to perform the necessary dental services I need.

Signature: _____ Date: _____