



# WELCOME

THANK YOU FOR PROVIDING THE FOLLOWING INFORMATION TO AID US IN YOUR CARE!

TODAY'S DATE: \_\_\_\_\_

## PERSONAL INFORMATION

NAME \_\_\_\_\_  
LAST FIRST MI

I WISH TO BE CALLED \_\_\_\_\_

SS# \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_

( ) MALE ( ) FEMALE ( ) SINGLE ( ) DIVORCED ( ) WIDOWED ( ) SEPARATED

HOME ADDRESS \_\_\_\_\_  
CITY STATE ZIP

WHOM MAY WE THANK FOR REFERRING YOU TO US? \_\_\_\_\_

## CONTACT INFORMATION

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

E-MAIL ADDRESS \_\_\_\_\_

WHICH IS THE BEST TO REACH YOU? ( ) HOME ( ) WORK ( ) CELL

WHEN IS THE BEST TIME TO REACH YOU? TIME \_\_\_\_\_ ( ) MON ( ) TUES ( ) WED ( ) THURS

## SPOUSE INFORMATION

HIS/HER NAME \_\_\_\_\_ SS# \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_ EXT. \_\_\_\_\_

## EMPLOYER

EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_

ADDRESS \_\_\_\_\_  
CITY STATE ZIP

HOW LONG EMPLOYED WITH THE ABOVE EMPLOYER? \_\_\_\_\_

## RESPONSIBLE PERSON

NAME \_\_\_\_\_ SS# \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_ HOME PHONE \_\_\_\_\_

BILLING ADDRESS \_\_\_\_\_  
CITY STATE ZIP

EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_ EXT. \_\_\_\_\_

## EMERGENCY INFORMATION

IN THE EVENT OF AN EMERGENCY, WHO SHOULD WE CONTACT?

NAME \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

## DENTAL INSURANCE INFORMATION

INSURANCE COMPANY NAME \_\_\_\_\_ PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_

GROUP # \_\_\_\_\_

INSURED'S NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ SS# \_\_\_\_\_

PLEASE CONTINUE TO YOUR MEDICAL HISTORY.

# MEDICAL REVIEW

## MEDICAL HISTORY

**HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> AIDS/HIV POSITIVE    | <input type="checkbox"/> DRUG/ALCOHOL ABUSE              | <input type="checkbox"/> HEPATITIS               |
| <input type="checkbox"/> ANEMIA               | <input type="checkbox"/> EPILEPSY/SEIZURES               | <input type="checkbox"/> HIGH/LOW BLOOD PRESSURE |
| <input type="checkbox"/> ARTIFICIAL JOINTS    | <input type="checkbox"/> EMPHYSEMA                       | <input type="checkbox"/> LATEX ALLERGY           |
| <input type="checkbox"/> ARTHRITIS/RHEUMATISM | <input type="checkbox"/> GLAUCOMA                        | <input type="checkbox"/> MITRAL VALVE PROLAPSE   |
| <input type="checkbox"/> ASTHMA               | <input type="checkbox"/> HEADACHES                       | <input type="checkbox"/> PANIC DISORDER          |
| <input type="checkbox"/> CHEMOTHERAPY         | <input type="checkbox"/> HEART PACEMAKER                 | <input type="checkbox"/> RHEUMATIC FEVER         |
| <input type="checkbox"/> DIABETES             | <input type="checkbox"/> HEART PROBLEMS/ATTACK           | <input type="checkbox"/> STROKE                  |
|   | <input type="checkbox"/> HEART MURMUR                    |  |
|   | <input type="checkbox"/> HEART SURGERY/VALVE REPLACEMENT |  |

## MEDICATIONS

**ARE YOU TAKING OR ALLERGIC TO ANY ONE OF THESE MEDICATIONS?**

- ASPIRIN    COUMADIN/BLOOD THINNER    ERYTHROMYCIN    PENICILLIN/AMOXICILLIN  
 CODIENE    DENTAL ANESTHETICS

**LIST ANY MEDICATIONS YOU ARE TAKING (PRESCRIPTION OR OVER-THE-COUNTER)**

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## FEMALE PATIENTS

**ARE YOU PREGNANT?**  YES  NO

**ARE YOU TAKING BIRTH CONTROL PILLS?**  YES  NO

## PHYSICIAN INFORMATION

**DO YOU HAVE A PERSONAL PHYSICIAN?**  YES  NO

**IF YES, PHYSICIAN NAME** \_\_\_\_\_ **PHONE** \_\_\_\_\_

**ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN?**  YES  NO

**IF YES, PLEASE EXPLAIN** \_\_\_\_\_

**NAME OF PHYSICIAN** \_\_\_\_\_ **PHONE** \_\_\_\_\_

**MY PHYSICAL HEALTH IS:**  GOOD  FAIR  POOR

**WEIGHT** \_\_\_\_\_ **HEIGHT** \_\_\_\_\_

## NOTES

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# DENTAL REVIEW

## GENERAL QUESTIONS

WHAT IS YOUR REASON FOR TODAY'S VISIT? \_\_\_\_\_

WHEN WAS YOUR LAST DENTAL VISIT? \_\_\_\_\_

WHAT WAS DONE AT YOUR LAST VISIT? \_\_\_\_\_

HOW WOULD YOU RATE YOUR DENTAL HEALTH? ( )EXCELLENT ( )GOOD ( )FAIR ( )POOR

HOW HAVE YOUR PREVIOUS DENTAL EXPERIENCES BEEN? ( )GREAT ( )OK ( )BAD

HOW OFTEN DO YOU BRUSH? \_\_\_\_\_ FLOSS? \_\_\_\_\_

## FRONT TEETH

ARE YOU HAPPY WITH THEIR COLOR? ( )YES ( )NO

ARE YOU HAPPY WITH THEIR LENGTH? ( )YES ( )NO

ARE THEY CROWDED, CROOKED, OR HAVE GAPS? ( )YES ( )NO

DO YOU HAVE OLD FILLINGS OR DENTAL WORK THAT YOU DON'T LIKE? ( )YES ( )NO

ANYTHING ABOUT THEM YOU WOULD CHANGE? \_\_\_\_\_

## BACK TEETH

ARE YOUR TEETH SENSITIVE TO: ( )COLD ( )HOT ( )BITING PRESSURE ( )NONE

DO YOU TRAP FOOD BETWEEN YOUR TEETH? ( )YES ( )NO

DO YOU HAVE OLD FILLINGS OR DENTAL WORK THAT YOU DON'T LIKE? ( )YES ( )NO

ANYTHING ABOUT THEM YOU WOULD CHANGE? \_\_\_\_\_

## GUMS

HAVE YOU EVER HAD GUM DISEASE? ( )YES ( )NO

DO YOU SEE A PERIODONTIST? ( )YES ( )NO IF YES, NAME \_\_\_\_\_

DO YOUR GUMS BLEED? ( )YES ( )NO

DO YOU HAVE BAD BREATH? ( )YES ( )NO

ANYTHING ABOUT THEM YOU WOULD CHANGE? \_\_\_\_\_

## MISSING TEETH

ARE YOU MISSING ANY TEETH? ( )YES ( )NO

ARE YOU WEARING ANY REPLACEMENT TEETH? ( )YES ( )NO

ANYTHING ABOUT THEM YOU WOULD CHANGE? \_\_\_\_\_

## MISCELLANIOUS

DO YOU SNORE? ( )YES ( )NO

DO YOU HAVE SLEEP APNEA? ( )YES ( )NO

DO YOU GRIND YOUR TEETH? ( )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. I ALSO GIVE DR. PALMER PERMISSION TO USE, REPRODUCE AND PUBLISH MY PHOTOGRAPHS FOR EDUCATIONAL, LECTURE AND/OR MARKETING PUPOSES. I GRANT PERMISSION FOR MARK PALMER, DDS, PA AND ITS ASSIGNED TO TELEPHONE ME AT HOME OR WORK TO DISCUSS MATTERS RELATED TO MY DENTAL CARE.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY \_\_\_\_\_

DATE \_\_\_\_\_

PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.