WELCOME TO OUR OFFICE!

TODAY WE WILL TAKE THE FIRST STEP TOWARD A COMPREHENSIVE EXAMINATION AND EVALUATION OF YOUR MOUTH. ACCURATE ANSWERS TO THE FOLLOWING QUESTIONS CAN HELP US HELP YOU. ANY ADDITIONAL INFORMATION YOU THINK MIGHT BE HELPFUL WILL BE APPRECIATED.

Lisa B. Masters, DDS,MS W. Bradley Woods, DDS Victoria A. Vickers, DDS

Patient Information

Patient Name: _____ Date:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Address: _____
Street Apartment #

_____
City State Zip Code

Social Security #: _____ Birth Date:_____Age_____

Phone (Home): _____ (Cell): _____ (Work): _____ Ext:_____

Best time to call: _____

E-mail Address:_____ Best contact method: Phone____ E-mail____

Spouse's Name_____ Spouse's Employer_____

Name of Friend or Relative_____ Phone_____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐T ☐F

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other_____

Name of person or office referring you to our practice:_____

GENERAL DENTAL INFORMATION

- Reason for today's visit: _____
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:_____
- Do you have any old fillings or dental work that you do not like? _____
- Do you use floss?_____ Toothpicks?_____ How often?_____
- If money were no object, what would you like to change about your mouth?_____
  _____
- Do you drink tea or coffee with sugar?_____ Do you drink soft drinks with sugar?_____
- Do you use breath mints, cough drops, or hard candy?_____

PERIODONTAL INFORMATION

• Pain in teeth or gums	YES	NO	Clench or grind teeth at night	YES	NO
• Bleeding gums while brushing	YES	NO	Teeth separating & causing spaces	YES	NO
• Abscesses or gum swelling	YES	NO	Any teeth feeling loose	YES	NO
• Bad taste in mouth	YES	NO	Unsatisfactory chewing	YES	NO
• Teeth sensitive to hot, cold, or sweets	YES	NO	Calculus forms rapidly on teeth	YES	NO

IMPLANT/PROSTHETIC INFORMATION

- Do you have a removable dental appliance? Upper_____ Lower_____
- How long have you had it? Upper_____ Lower_____
- Is the appliance satisfactory? Upper _____ Lower_____
- If not, what is not satisfactory? Upper_____
  Lower_____
- When did you loose your missing teeth? Upper_____ Lower_____
- Are you considering Dental Implants? _____
- Are you considering new dentures? _____

- **Health Information**

Weight_____ Height_____

Have you ever had any of the following? Please check those that apply:

☐ Arthritis
☐ Artificial Joints/Hip/Knee
☐ Asthma
☐ Aspirin
☐ Alzheimer's Disease
☐ Blood Disease
☐ Breathing Difficulties
☐ Cancer _____
☐ Radiation Treatment
☐ Chemotherapy
☐ Diabetes Blood Sugar _____
☐ Epilepsy/Seizures
☐ Excessive Bleeding
☐ Glaucoma
☐ Heart Disease
☐ Heart valve replacement
☐ Pacemaker or defibrillator
☐ Heart Murmur
☐ High/Low Blood Pressure
☐ HIV/AIDS
☐ Kidney Disease
☐ Liver Disease
☐ Hepatitis A B C
☐ General Anxiety
☐ Depression
☐ Bipolar disorder
☐ Schizophrenia
☐ ADHD
☐ Eating disorder
☐ Pregnancy
Due date:_____
☐ Rheumatic Fever
☐ Stomach Problems
☐ Acid Reflux
☐ Stroke/TIA
☐ Urinary Problems
☐Increased Frequency of Urination
☐ Sinus Problems
☐ Thyroid Problems

ALLERGIES:
☐ Codeine Allergy
☐ Metal Allergy (Costume Jewelry)
☐ Penicillin Allergy
☐ Seasonal Allergies
☐ Latex Allergy
☐ Other allergies:
_____

Other concerns regarding your health:
_____

GENERAL MEDICAL INFORMATION
List all medications (prescription & over-the-counter):_____

_____

- Do you take any of the following herbal remedies or vitamins:

❑ Garlic
❑ Ginkgo
❑ Ginger
❑ Kava
❑ Valerian
❑ Multi Vitamin
❑ Vitamin E
❑ Vitamin C
❑ Calcium
❑ Ginseng
❑ Echinacea
❑ St. John's Wart

- Name of physician:_____Telephone:_____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain:_____
- Do you smoke?_____ How much?_____ For how many years?_____
- How many alcoholic beverages do you have each day?_____ Each week?_____

Consent for Services

To the best of my knowledge, all the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail. I understand that payment is due at the time service is rendered unless other financial arrangements have been made with the doctors. I understand that late charges will be added to any unpaid balance due at a rate of 18% per annum. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.
I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian