WELCOME

The Island Dentist

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

About You

Today's Date _____

Name: _____

I prefer to be called _____ ❒ Male ❒ Female

Home Address: _____

City _____ State ____ Zip _____

Hobbies: _____

Birthdate: ___/___/___ Age: ___ SS#: _____

If child, parents name: _____

❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Separated

Home #: _____ Cell #: _____

WK # _____ Ext _____ DL #: _____

Employer: _____

Employer's Address: _____

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: _____

Spouse Information

His / Her Name: _____

Employer: _____

WK#: _____ Ext: _____ SS #: _____

Birthdate: ___/___/___ DL #: _____

Person Responsible for Account: _____

Wk #: _____ Ext: _____ HM #: _____

Billing Address: _____

Relationship _____ SS #: _____

Employer: _____ DL #: _____

Dental Insurance

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Tel. #: _____

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

Insured's Name: _____ Relationship: _____

Insured's Birthday: ___/___/___ Insured's SS #: _____

Insured's Employer: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Tel. #: _____

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

Insured's Name: _____ Relationship: _____

Insured's Birthday: ___/___/___ Insured's SS#: _____

Insured's Employer: _____

Medical History

Do you have a personal physician? **No** **Yes**

Physician's Name: _____

Phone #: _____ Last Visit Date: _____

In the event of an emergency, is there someone who lives near you that we should contact?

Their Name: _____ Relationship: _____

WK #: _____ HM # _____

CONTINUED ON BACK OF FORM

Medical History continued

Your current physical health is ❒ Good ❒ Fair ❒ Poor

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

Please explain: _____

Are you taking any prescription / over-the-counter drugs?

❒ Yes ❒ No

Please list each one: _____

_____

_____

Are you taking birth control pills? ❒ 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?

Y N Heart Attack / Stroke	Y N Psychiatric Problems
Y N Heart Surgery / Pacemaker	Y N Cancer / Chemotherapy
Y N Epilepsy / Seizures / Fainting Spells	Y N Heart Murmur
Y N Diabetes / Tuberculosis (TB)	Y N Rheumatic Fever
Y N Drug / Alcohol Abuse	Y N HIV+ / AIDS
Y N Hemophililia / Abnormal Bleeding	Y N Venereal Disease
Y N Shingles	Y N Ulcers / Colitis
Y N Mitral Valve Prolapse	Y N Congenital Heart Defect
Y N Anemia / Radiation Treatment	Y N Kidney Problems
Y N Artifical Bones / Joints / Valves	Y N Asthma / Arthritis
Y N Tobacco	Y N Difficulty Breathing
Y N Hospitalized for any reason	Y N Sinus Problems
Y N High / Low Blood Pressure	Y N Hepatitis
Y N Fever Blisters	Y N Blood Transfusion
Y N Severe / Frequent Headaches	Y N Emphysema / Glaucoma
Y N Sleep Apnea	

Please list any other medical condition(s) that you may have

_____

_____

Are you allergic to any of the following?

Y N Penicillin	Y N Tetracycline	Y N Latex
Y N Aspirin	Y N Dental Anesthetics	Y N Other
Y N Erythromycin	Y N Codeine	

Please list any other allergies:

_____

_____

Dental History

Why have you come to the dentist today?

_____

_____

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 experience pain / discomfort in your jaw joint (TMJ / TMD)? ❒ yes ❒ no

Do you wear a night guard or ortho retainer? ❒ yes ❒ no

Your current dental health is ❒ Good ❒ Fair ❒ Poor

Do you like your smile? ❒ yes ❒ no

Do your gums ever bleed? ❒ yes ❒ no

How many times a week do you floss? _____

How many times a day do you brush? _____

Type of bristles? ❒ Hard ❒ Medium ❒ Soft

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 with my informed consent that I may need during diagnosis and treatment. Furthermore, I hereby consent to the use of my signature for all dental insurance submissions.

Signature _____ Date _____

Payment is due in full at the time of treatment unless prior arrangements have been approved.

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help.

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY

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

Doctors comments: _____

_____

MEDICAL HISTORY UPDATE

1. Date _____ Comments _____ Signature _____
2. Date _____ Comments _____ Signature _____
3. Date _____ Comments _____ Signature _____
4. Date _____ Comments _____ Signature _____
5. Date _____ Comments _____ Signature _____