

Welcome



About You

Patient Name _____
First MI Last
I prefer to be called: _____ Birthdate: ___/___/___ Social #: _____
Sex: Male Female Marital Status: Single Minor Married Divorced Widowed
Email: _____ **Driver License #:** _____

Home Address: _____
Street City State Zip

Home Phone #: (____) _____ **Cell Phone # :**(____) _____ **Work Phone # :**(____) _____

Whom may we thank for referring you? _____

Other Family Members seen here? _____

Employer: _____ How long there? _____ Occupation: _____

Employer's Address: _____
Street City State Zip

Neighbor or Relative not living with you?

His/Her Name: _____
First MI Last

Relation: _____ Work Phone: (____) _____ Home Phone: (____) _____

Address: _____
Street City State Zip

Spouse Information

His/Her Name: _____ Birthdate: ___/___/___ Social #: _____
First MI Last

Employer: _____ Work Phone: _____ Ext: _____ Drivers License: _____

Responsible Party

Person Responsible for Account if other than yourself

His/Her Name: _____
First MI Last

Relation: _____ Home Phone: (____) _____ Social #: _____ - _____ - _____

Employer: _____ Work Phone: (____) _____ Ext. _____ Drivers License: _____

Billing Address: _____
Street City State Zip

Insurance Information

Primary Insurance Information

Insured's Name: _____
First MI Last

Insured's Social #: _____ - _____ - _____ Insured's Birthdate: ___/___/___ Relation to patient: _____

Insured's Employer: _____

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

Insurance Co. Name: _____ Phone #: (____) _____

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

Insurance Co. Address: _____
Street City State Zip

Medical History Sheet



Women Only:

- | | | |
|--|-----|----|
| A) Are you pregnant or think you may be? | Yes | No |
| B) Are you nursing? | Yes | No |
| C) Are you taking oral contraceptives? | Yes | No |

- | | | |
|---|-----|----|
| 1 Are you currently in pain? | Yes | No |
| 2 Do you require antibiotics before dental treatment? | Yes | No |
| 3 Do you or have you ever experienced pain in your jaw joint (TMD / TMJ)? | Yes | No |
| 4 Do you use tobacco? | Yes | No |
| 5 Do you use controlled substances? | Yes | No |
| 7 Do you have a persistent cough or throat clearing? | Yes | No |

- | | | | | | |
|-----------------------|-----|----|----------------|-----|----|
| 8 Do you floss daily? | Yes | No | 9 Brush daily? | Yes | No |
|-----------------------|-----|----|----------------|-----|----|

- | | | |
|---|-----|----|
| 10 Would you like fresher breath? | Yes | No |
| 11 Would you like whiter teeth? | Yes | No |
| 12 Do your gums ever bleed? | Yes | No |
| 13 Have you ever had periodontal disease? | Yes | No |
| 14 Date of your last dental exam: _____ | | |

- | | | |
|---|-----|----|
| 15 Do your teeth move at all? | Yes | No |
| 16 Are your teeth sensitive to hot / cold / pressure? | Yes | No |
| 17 Do you still have your wisdom teeth? | Yes | No |

18 Previous/Present Dentist: _____
(Please circle)

19 Why did you leave your previous dentist? _____

20 What did you like most / least about your previous dentist? _____

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

22 If not, what would you change? _____

23. What medications are you currently taking?

24 Are you allergic to any of the follow:

Dental Anesthetics (e.g. Novocain)	Yes	No	Codeine	Yes	No	Aspirin	Yes	No
Penicillin or any Antibiotics	Yes	No	Erythromycin	Yes	No	Latex Rubber	Yes	No
Sulfa Drugs	Yes	No	Jewelry or Metals	Yes	No			
Other (please list): _____								

25. Do you have or have you had any of the following?

AIDS or HIV Infection	Yes	No	Glaucoma	Yes	No	Radiation Therapy	Yes	No
Anemia	Yes	No	Hay Fever/Allergies	Yes	No	Recent Weight Loss	Yes	No
Angina	Yes	No	Heart Attack	Yes	No	Respiratory Problems	Yes	No
Arthritis	Yes	No	Heart Disease	Yes	No	Rheumatic Fever	Yes	No
Asthma	Yes	No	Heart Murmur	Yes	No	Seizures	Yes	No
Cancer.	Yes	No	Hepatitis/Jaundice	Yes	No	Sexually Transmitted Disease	Yes	No
Cardiac Pacemaker	Yes	No	High Blood Pressure	Yes	No	Stomach Troubles/Ulcer	Yes	No
Diabetes	Yes	No	Joint Replacement/Implant	Yes	No	Stroke	Yes	No
Easily Winded	Yes	No	Kidney Disease	Yes	No	Swollen Ankles	Yes	No
Emphysema	Yes	No	Leukemia	Yes	No	Thyroid Problems	Yes	No
Epilepsy/Convulsions	Yes	No	Liver Disease	Yes	No	Tuberculosis	Yes	No
Frequently Tired	Yes	No	Low Blood Pressure	Yes	No	Other: _____		
			Mitral Valve Prolapse	Yes	No	_____		

26. Authorizations

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

Signature _____

Date _____

Payment is due at time of Service

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

I certify that I am covered by _____ Insurance Co. and I assign directly to Rousseau Family Dentistry, PC all insurance benefits, otherwise payable to me. I understand I am responsible for payment of services rendered and also responsible for paying any copayment 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 _____