

ABOUT YOU

Today's Date: _____

Name: _____ Female Male
Home Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Birth Date: ____/____/____ SSN: _____ Driver License No.: _____
E-mail Address: _____
Employer: _____
Position: _____
Business Address: _____
Marital Status: Single Married Widowed Spouse's Work Phone: _____
Name of Spouse: _____ Spouse's Cell Phone: _____
Spouse's Birth Date: ____/____/____ Spouse's SSN: _____
Spouse's Employer: _____
Children's Names & Ages: _____

Whom may we thank for referring you: _____

TELL US ABOUT YOUR MEDICAL HISTORY

Name of personal physician: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Approximate date of last visit: _____ Current health condition: Excellent Good Fair Poor
Have you had any serious health problems in the last five years? Yes No If yes, please explain: _____

(For women) Are you currently pregnant: Yes No If yes, how many months? _____
Do you take any vitamin or herbal supplements: Yes No If yes, what kind: _____
Are you currently taking: A beta-blocker: Yes No A monoamine oxidase inhibitor (MAOI) Yes No
Please list any other prescription medications and their purpose: _____

When was your last blood pressure reading? _____ What was it? _____

Please indicate if you currently have or have ever been treated for the following:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Open Heart Surgery | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Surgery With Pins |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Artificial Valve | <input type="checkbox"/> Prosthetic Implant | <input type="checkbox"/> Artificial Joints |

The following conditions may require a pre-medication. Please check if any of these apply to you:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Abnormal Blood Pressure | <input type="checkbox"/> Family History of Diabetes | <input type="checkbox"/> Excessive Urination | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> AIDS / ARC | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Fainting Spell | <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Anemia | <input type="checkbox"/> Transplant Surgery | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Heart Attack / Stroke | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Tumor |
| <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Nervous Disorder | <input type="checkbox"/> Psychiatric Condition | <input type="checkbox"/> Drug / Alcohol Abuse | <input type="checkbox"/> Bruise Easily |

Please check if you're allergic to any of the following:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Local anesthetics | <input type="checkbox"/> Codeine or Other Narcotics | <input type="checkbox"/> Latex Sensitivity | <input type="checkbox"/> Shellfish, Iodine or |
| <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Sedatives, Sleeping Pills | <input type="checkbox"/> Red Wine |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Other: _____ | | |

EMERGENCY INFORMATION

Person to contact: _____ Relationship: _____
Phone #: _____ Cell #: _____ Work #: _____
Address: _____

INSURANCE INFORMATION

Insurance is a contract between you and your insurance company. We will bill your insurance company as a courtesy to you.

Please bring your dental card with you to your appointment.

Subscriber to Insurance: (Last Name, First Name) _____

D.O.B. ____/____/____ SSN and/or Insurance ID# _____

Name of Insurance: _____ Phone: _____

Employer Insured is Through: _____ Phone: _____

DENTAL HISTORY

What prompted you to call our office? _____

When was your last dental visit? _____

Previous dentist's name: _____

What did you like or dislike about your last dentist experience? _____

How do you rate your smile from 1-10 (1 being not pleased and 10 being very pleased)? _____

What would you most want to change about your teeth/smile? _____

PLEASE READ AND SIGN BELOW:

When a health care worker is exposed to my blood or body fluids through a needle stick, cut, or splash to the eye or mouth, I agree to have my blood tested for blood-borne diseases including but not limited to Hepatitis B and C virus and human Immunodeficiency Virus (AIDS).
Initial: _____

I certify that the above information is accurate and true to the best of my knowledge. I also understand:

- As a condition of treatment, all financial arrangements must be made in advance.
- If I have dental insurance, all dental services furnished are charged directly to me and I am personally responsible for payment of all dental services.
- Any claims not paid by my dental insurance within 60 days of treatment is due immediately.
- Any treatment diagnosed is only an estimate of services and under some circumstances the treatment may become more extensive and have additional charges.
- Utica Dental may make alteration to my treatment should the need arise. The office will make every effort to explain any treatment changes and their associated fees before continuing.
- All treatment fees presented will be honored for 6 months.
- Utica Dental or team members have permission to contact me by telephone at my home or work to discuss my treatment, insurance, or account

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

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