Welcome

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

1 ABOUT YOU

Today's Date: _____
E-mail Address: _____
Name: _____

I prefer to be called: _____ Male Female
Birthdate: ____/____/____ Age: _____
Home Address: _____
_____

Single Married Divorced Widowed Separated
Home #: (____)_____ Cell #: (____)_____
Work #: (____)_____ Ext: _____ DL #: _____
Employer: _____
Employer's Address: _____
How long there? _____ Occupation: _____
Where & when are best times to reach you? _____
Whom may we thank for referring you? _____
Other family members seen by us: _____
Previous / Present Dentist: _____

Last Visit Date: _____

2 SPOUSE INFORMATION

His / Her Name: _____
Employer: _____
Wk #: (____)_____ Ext: _____
Birthdate: ____/____/____ DL #: _____

Person Responsible for Account: _____
Wk #: (____)_____ Ext: _____ Hm #: (____)_____
Billing Address: _____
Relationship: _____
Employer: _____ DL #: _____

3 INSURANCE

Primary Insurance

Dental Coverage? Yes No
Insurance Co. Name: _____
Insurance Co. Address: _____
Insurance Co. Phone #: (____)_____
Group # (Plan, Local or Policy #): _____
Insured's Name: _____ Relation: _____
Insured's Birthdate: ____/____/____ Insured's ID #: _____
Insured's Employer: _____
Employer's Address: _____

Secondary Insurance

Dental Coverage? Yes No
Insurance Co. Name: _____
Insurance Co. Address: _____
Insurance Co. Phone #: (____)_____
Group # (Plan, Local or Policy #): _____
Insured's Name: _____ Relation: _____
Insured's Birthdate: ____/____/____ Insured's ID #: _____
Insured's Employer: _____
Employer's Address: _____

Neighbor or Relative not living with you.

His / Her Name: _____ Relation: _____
Wk #: (____)_____ Hm #: (____)_____
Address: _____
_____

4 MEDICAL HISTORY

Do you have a personal physician? Yes No

Physician's Name: _____
Phone #: (____)_____ Date of last visit: _____
Are you currently under the care of a physician? Yes No
Please explain: _____

RONALD T. BLANCHETTE, D.D.S.

CONTINUED ON BACK

4 MEDICAL HISTORY CONTINUED

Your current physical health is: Good Fair Poor

Do you smoke or use tobacco in any other form? Yes No

Have you had any metal rods, pins or implants? Yes No

Are you taking any prescription / over-the-counter or herbal supplemental drugs? Yes No

Please list each one: _____

_____

Have you ever taken Fosamax, or any other bisphosphonate? Yes No

Have you ever taken Phen-Fen? Yes No

For Women: Are you using a prescribed method of birth control? Yes No

Are you pregnant? Yes No Week #: _____

Are you nursing? Yes No

Have you every had any of the following diseases or medical problems

Y	N	Abnormal Bleeding	Y	N	Herpes / Fever Blisters
Y	N	Alcohol / Drug Abuse	Y	N	High Blood Pressure
Y	N	Anemia	Y	N	HIV+ / AIDS
Y	N	Arthritis	Y	N	Hospitalized for Any Reason
Y	N	Artificial Bones / Joints / Valves	Y	N	Kidney Problems
Y	N	Asthma	Y	N	Liver Disease
Y	N	Blood Transfusion	Y	N	Low Blood Pressure
Y	N	Cancer / Chemotherapy	Y	N	Lupus
Y	N	Colitis	Y	N	Mitral Valve Prolapse
Y	N	Congenital Heart Defect	Y	N	Osteoporosis / Paget's Disease
Y	N	Diabetes	Y	N	Pacemaker
Y	N	Difficulty Breathing	Y	N	Psychiatric Problems
Y	N	Emphysema	Y	N	Radiation Treatment
Y	N	Epilepsy	Y	N	Rheumatic / Scarlet Fever
Y	N	Fainting Spells	Y	N	Seizures
Y	N	Frequent Headaches	Y	N	Shingles
Y	N	Glaucoma	Y	N	Sickle Cell Disease / Traits
Y	N	Hay Fever	Y	N	Sinus Problems
Y	N	Heart Attack	Y	N	Stroke
Y	N	Heart Murmur	Y	N	Thyroid Problems
Y	N	Heart Surgery	Y	N	Tuberculosis (TB)
Y	N	Hemophilia	Y	N	Ulcers
Y	N	Hepatitis	Y	N	Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following?

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

Please list any other drugs / materials that you are allergic to: _____

_____

5 DENTAL HISTORY

Why have you come to the dentist today? _____

_____

Do you require antibiotics before dental treatment? Yes No

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 have fears about going to the dentist? Yes No

Have you every had gum treatment? Yes No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? Yes No

Your current detal heal is Good Fair Poor

Do you like your smile? Y N Do your gums ever bleed? Y N

How many times a week do you floss? _____ a day do you brush? _____

Types of bristles? Soft Medium Hard

How long do you use a toothbrush before replacing it? _____

Are your teeth sensitive to heat, cold, or anything else? _____

Have you lost any teeth? Yes No If yes, why? _____

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.

_____

Signature Date

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

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

_____

Signature Date

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

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

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

Doctor's Comments: _____

_____

MEDICAL HISTORY UPDATE

I have read my medical history dated _____ and confirmed that it states past and present medical conditions. _____
Signature Date

I have read my medical history dated _____ and confirmed that it states past and present medical conditions. _____
Signature Date

I have read my medical history dated _____ and confirmed that it states past and present medical conditions. _____
Signature Date