



PATIENT INFORMATION

Last Name _____ First Name _____ MI _____

Preferred Name _____ Married _____ Single _____ Child _____

Date of Birth ____/____/____ Social Security Number ____-____-____

Address _____ City _____ State _____ Zip Code _____

Home Phone(____) _____ Work Phone(____) _____ Cell Phone(____) _____

E-mail _____ Employer _____

How did you find out about our office? _____

POLICY HOLDER'S INSURANCE INFORMATION

Name _____ Relationship to patient _____

Date of Birth ____/____/____ Social Security Number ____-____-____

Employer _____ Work Phone Number ____-____-____

Insurance Company _____

Subscriber ID Number _____ Group number _____

PAYMENT PREFERANCES

Please select from the following list your preferred method of payment.

- Payment by Cash (Please ask about our 5% Pre-pay discount)
- Payment by Check(Please ask about our 5% Pre-pay discount)
- Payment by Credit Card (**MasterCard, Visa, Discover**)
- Automatic Monthly Billing to your Credit Card
- Automatic billing of any amount not covered by insurance to you Credit Card, once insurance had paid (*credit card number will be kept on file*)

We offer financing options such as, Care Credit and Unicorn. Please ask our receptionist for more information, and applications.

DENTAL HISTORY

Reason for today's visit? _____

Have you ever been told you have gum disease? YES _____ NO _____

Do you have pain or painful popping in your jaws/ TMJ disorders? YES _____ NO _____

Do you think you may have cavities? YES _____ NO _____

Are there things you would like to change about your smile? YES _____ NO _____

Would you like to whiten your teeth? YES _____ NO _____

Do you have old fillings or crowns you wished looked better? YES _____ NO _____

HEALTH HISTORY

Have you had, or do you currently have?

| | YES | NO | | YES | NO |
|----------------------------------|-------|-------|------------------------------|-------|-------|
| Prosthetic (artificial) joint(s) | _____ | _____ | Hepatitis, Liver Disease | _____ | _____ |
| Rheumatic Fever | _____ | _____ | Fainting Spells | _____ | _____ |
| Damaged Heart Valves | _____ | _____ | Epilepsy, Convulsions | _____ | _____ |
| Heart Murmur | _____ | _____ | Stroke | _____ | _____ |
| High Blood Pressure | _____ | _____ | Thyroid Problems | _____ | _____ |
| Low Blood Pressure | _____ | _____ | Diabetes | _____ | _____ |
| Chest Pains, Angina | _____ | _____ | Low Blood Sugar | _____ | _____ |
| Heart Attack (s) | _____ | _____ | Kidney Problems | _____ | _____ |
| Irregular Heart Beat | _____ | _____ | Arthritis, Joint Disease | _____ | _____ |
| Cardiac Pacemaker | _____ | _____ | Stomach Ulcers | _____ | _____ |
| Heart Surgery | _____ | _____ | Contagious Disease(s) | _____ | _____ |
| Bronchitis, Chronic Cough | _____ | _____ | Sexually Transmitted Disease | _____ | _____ |
| Asthma | _____ | _____ | Immunosuppressed (HIV) | _____ | _____ |
| Tuberculosis | _____ | _____ | Tumors(s) | _____ | _____ |
| Emphysema | _____ | _____ | Chemo/Radiation Therapy | _____ | _____ |
| Difficulty Breathing | _____ | _____ | History of Drug Abuse | _____ | _____ |
| Blood Disorder/Anemia | _____ | _____ | Mental Health Problems | _____ | _____ |
| Bleed Easily | _____ | _____ | History of Alcohol Abuse | _____ | _____ |
| Chronic Sinus Problems | _____ | _____ | Do You Use Tobacco | _____ | _____ |

Have you ever been told you should take **antibiotics before your dental visits**? YES _____ NO _____

Do you take any medications for **OSTEOPOROSIS**, such as **BONIVA, FOSAMAX, ACTONEL**, or any other **BISPHOSPHONATE DRUGS**? YES _____ NO _____

MEDICATIONS/ ALLERGIES

Are you taking any anticoagulants medicines, such as **COUMADIN, PLAVIX, ASPRIN**, etc.?
YES _____ NO _____

Please list any **medications** you take regularly, or have taken in the last two weeks.
(if you need more space, please use the medications form on the back of this page)

Are you allergic to **PENICILLIN**? YES _____ NO _____
Are you allergic to any **other MEDICATIONS**? YES _____ NO _____

If so please list them:

Please list any other allergies you may have (**LATEX, METALS, ENVIRONMENTAL ALLERGIES**).

WOMEN

Is there a possibility you are pregnant? YES _____ NO _____
Are you nursing? YES _____ NO _____
Are you taking birth control pills? YES _____ NO _____

NOTE: Antibiotics (such as Penicillin, and many others) may alter the effectiveness of BIRTH CONTROL PILLS.
Consult your Physician or Gynecologist regarding additional methods of birth control if you start taking any antibiotics.

ANXIETY

On a scale from 1-10 how nervous are you about having dental work done?
(not nervous at all) (very nervous)
1 2 3 4 5 6 7 8 9 10

Are you interested in using nitrous oxide (**laughing gas**)
for you dental visits? (there is a fee for this service) YES _____ NO _____

Are you interested in using stronger oral medications, such
as, **VALLIUM, HALCION, LORAZAPAM** for your dental visits.
(there is a fee for this service) YES _____ NO _____

I certify that I have read the questions above completely. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold Dr. Decker, staff or any other Dentist practicing in this office responsible for any problems or complications that may result from any omission or errors I have made in the completion of this form.

Signature _____ **Date** _____

Signature of Parent (if patient is less than 18 years old) _____ **Date** _____
