Rhodes Dental

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 completely. The better we com- the better we can care for you.

About You

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

Name: _____
LAST FIRST MI MR MRS MS DR

I prefer to be called: _____ ☐ Male ☐ Female

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

Home Address: _____
APT / CONDO #

_____
CITY STATE ZIP

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm #: (___)_____ Pager / Other #: _____

Wk #: (___)_____ 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: _____
(Please Circle)

Last Visit Date: _____

Spouse Information

His / Her Name: _____

Employer: _____

Wk #: (___)_____ Ext: ____ SS #: _____

Birthdate: ___/___/___ DL #: _____

Person Responsible for Account: _____

Wk #: (___)_____ Ext: ____ Hm #: (___)_____

Billing Address: _____

Relation: _____ SS #: _____

Employer: _____ DL #: _____

Dental Insurance

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #:(___)_____

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

Insured's Name: _____ Relation: _____

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

Insured's Employer: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #:(___)_____

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

Insured's Name: _____ Relation: _____

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

Insured's Employer: _____

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

His / Her Name: _____ Relation: _____

Wk #: (___)_____ Hm #: (___)_____

Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Phone #: (___)_____ Date of last visit: _____

CONTINUED ON BACK

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: _____

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

For Women: 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	Anemia /Radiation Treatment	Y	N	Heart Surgery / Pacemaker
Y	N	Artificial Bones / Joints	Y	N	Hemophilia / Abnormal Bleeding
Y	N	Artificial Valves	Y	N	Hepatitis
Y	N	Asthma / Arthritis	Y	N	High / Low Blood Pressure
Y	N	Blood Transfusion	Y	N	HIV+ / AIDS
Y	N	Cancer / Chemotherapy	Y	N	Hospitalized for Any Reason
Y	N	Congenital Heart Defect	Y	N	Kidney Problems
Y	N	Diabetes / Tuberculosis (TB)	Y	N	Mitral Valve Prolapse
Y	N	Difficulty Breathing	Y	N	Psychiatric Problems
Y	N	Drug / Alcohol Abuse	Y	N	Rheumatic / Scarlet Fever
Y	N	Emphysema / Glaucoma	Y	N	Severe / Frequent Headaches
Y	N	Epilepsy / Seizures / Fainting Spells	Y	N	Shingles
Y	N	Fever Blisters / Herpes	Y	N	Sinus Problems
Y	N	Heart Attack / Stroke	Y	N	Ulcers / Colitis
Y	N	Heart Murmur	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**	Y	N	**Jewelry/Metals**

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

_____

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 now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ 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? _____ 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 responsiblity to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

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 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 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

1. Date: _____ Comments: _____ Signature: _____

2. Date: _____ Comments: _____ Signature: _____

3. Date: _____ Comments: _____ Signature: _____