WELCOME TO Century Dental L.L.C.

Date_____

Update_____

Update_____

PATIENT

NAME LAST_____ FIRST_____ M.I.____

*ADDRESS*_____ CITY_____ STATE_____ ZIP_____

*DATE OF BIRTH*_____

*HOME PHONE (_____)*_____ *BUSINESS PHONE (_____)*_____ *Ext.*_____

*CELL PHONE (_____)*_____

*SOCIAL SECURITY*_____ *DRIVERS LICENSE*_____

(IF OVER 18)

PARTY RESPONSIBLE FOR BILL

*SOCIAL SECURITY*_____ *DRIVERS LICENSE*_____

NAME LAST_____ FIRST_____ M.I.____

*ADDRESS*_____ CITY_____ STATE_____ ZIP_____

*DATE OF BIRTH*_____

*HOME PHONE (_____)*_____ *BUSINESS PHONE (_____)*_____ *Ext.*_____

OCCUPATION _____ *YRS. W/ FIRM*_____

*EMPLOYER*_____

*EMPLOYER ADDRESS*_____

*SPOUSE NAME*_____ *DATE OF BIRTH*_____

*SPOUSE EMPLOYER*_____

*SPOUSE EMPLOYER ADDRESS*_____ *OCCUPATION*_____

*PHONE*_____

DENTAL INSURANCE

PRIMARY _____ ***SECONDARY*** _____

*NAME OF INSURANCE*_____ *NAME OF INSURANCE*_____

*ADDRESS*_____ *ADDRESS*_____

*PHONE*_____ *GROUP#*_____ *PHONE*_____ *GROUP#*_____

*SS#*_____ *DOB*_____ *SS#*_____ *DOB*_____

Whom may we contact in case of emergency?:

*NAME*_____ *NAME*_____

*PHONE*_____ *PHONE*_____

*OTHER*_____ *OTHER*_____

REFERRED BY

____PATIENT NAME_____
____MAILING
____TELEVISION AD
____VAL PAK
____NEWS PAPER
____SIGN/AREA
____RADIO
____PHYSICIAN
____YELLOW PAGES
____OTHER_____

Name_____

Medical History

please intial

__ ARTHRITIS
__ ALCOHOLISM
__ GLAUCOMA
__ ARTIFICIAL JOINTS
__ LIVER DISEASE
__ JAUNDICE
__ HEPATITIS
__ BLOOD DISEASE
__ ANEMIA
__ HIV / AIDS
__ TUBERCULOSIS
__ KIDNEY DISEASE
__ HORMONE SUPPLEMENTS
__ BIRTH CONTROL PILLS
__ THYROID DISTURBANCE
__ DIABETES: ___ type 1-insulin ___type 2-oral medication
__ HEART DISEASE
__ ANGINA
__ HEART ATTACK
__ HEART MURMUR
__ MITRAL VALVE PROLAPSE
__ RHEUMATIC FEVER
__ HIGH BLOOD PRESSURE
__ CANCER: type of cancer_____
year treated_____
__ RADIATION TREATMENT
__ CHEMOTHERAPY
__ TUMORS
__ STOMACH PROBLEMS
__ ULCERS
__ GASTRIC REFLUX
__ STROKE
__ MENTAL DISORDERS
__ DEPRESSION
__ EATING DISORDER
__ PANIC ATTACKS
__ SINUS PROBLEM
__ HAY FEVER
__ RESPIRATORY DISEASE
__ ASTHMA
__ LATEX ALLERGY

Drug Allergies

__ PENICILLIN __ CODEINE
__ ASPIRIN __ NOVOCAINE
__ OTHER:Please List_____

_____

_____

Current Medications

Please List:_____

_____

_____

ARE YOU PREGNANT? Yes __ No __

Dental History

LAST DENTAL CLEANING_____ LAST DENTAL EXAM_____
DO YOU SMOKE?_____ HOW MUCH?_____
ARE YOU IN DISCOMFORT TODAY?_____ WHERE?_____
WHAT CONCERNS YOU MOST ABOUT YOUR TEETH AND GUMS?_____

_____

DO YOU GET COLD SORES?_____
WOULD YOU LIKE WHITER TEETH?_____
WHAT PRODUCTS DO YOU CURRENTLY USE TO MANAGE BAD BREATH?_____

WARNING: Being under the influence of ALCOHOL, COCAINE, or OTHER ILLEGAL SUBSTANCES during dental treatment can adversely affect your health.

ARE YOU NOW OR IN THE LAST 48 HOURS, BEEN UNDER THE INFLUENCE OF ALCOHOL, COCAINE, or other ILLEGAL SUBSTANCES? ___ YES ___ NO

SIGNATURE_____ DATE_____

OFFICE USE ONLY

I HAVE REVIEWED MY PREVIOUS MEDICAL HISTORY AND THERE ARE NO CHANGES_____ THERE ARE CHANGES_____
INITIAL INITIAL

_____ _____
PATIENT, PARENT OR GUARDIAN DATE PATIENT, PARENT OR GUARDIAN DATE

_____
DOCTOR UPDATE DATE DATE DATE