Welcome to Glenwood Village Dentistry

The benefits of a happy health 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.

About You **today's Date:** _____

Email address: _____
Last Name: _____ First: _____MI: _____
I preferred to be Called: _____ Male: _____ Female: _____
Birth date: ___/___/___ Age: _____ SS#:_____

Home Address: _____Apt#:_____
_____
city **state** **zip**
Single: _____ Married: _____ Divorce: _____ Widowed: _____ Separated: _____
Home#: _____ Cell#:_____
Work#: _____ext:_____ DL#: _____
Employer: _____ Occupation: _____
Where and when is the best time to reach you? _____
Whom may we thank for referring you? _____
Other family members we may have seen: _____
Previous / Present dentist: _____ Last Visit date: _____
Please circle

Spouse information:
Her/His Name: _____ Employer: _____
Work#:_____ SS#_____
Birth date: ___/___/___ Dl#: _____

Person Responsible for Account:
Name: _____ Relation: _____
SS#:_____ DL#:_____
Employer: _____ Work#: _____ EXT: _____

Dental Insurance information: The insured party is the person with who works for the employer who supplies the insurance unless it is a self paid for plan:

Primary Dental Insurance:
Insurance Company: _____ Ins. Address: _____
Insurance Phone#:_____ Group #:_____
Insured Legal Name: _____ Insured Birth date: ___/___/___
Insured Employer: _____ Insured Work#: _____

Secondary Dental Insurance:
Insurance Company: _____ Ins. Address: _____
Insurance Phone#:_____ Group #:_____
Insured Legal Name: _____ Insured Birth date: ___/___/___
Insured Employer: _____ Insured Work#: _____

In the event of an emergency, is there someone who lives near you we should contact?
Name: _____ Relation: _____
Home#:_____ Cell#: _____ Work#: _____

Medical History

Do you have a personal Physician? Yes / No
Name of Physician: _____ Work#: _____ Last Visit Date: _____
Are you currently under the care of a Physician: Yes / No please explain:
_____
Is your current Health: Good: _____ Fair: _____ Poor: _____
Are you taking any prescription/ over the counter or supplemental drugs? Yes / No
Please List each one: _____
_____
_____
If you list is extensive please attach a copy.

Do you smoke or use tobacco in any other form?	Yes / No
Have you taken Fosamax, or any other bisphosphonate?	Yes / No
Have you taken any Phe-Fen?	Yes / No
For Women: Are you using a prescribed method of birth control?	Yes / No
Are you pregnant?	Yes / No
Are you nursing?	Yes / No

Do you have any of the following medical conditions? Please circle either YES or NO

Anemia/Radiation Treatment	Y	N	Hemophilia	Y	N
Artificial Bone/Joint/Valves	Y	N	Hepatitis	Y	N
Arthritis	Y	N	High/Low blood Pressure	Y	N
Asthma	Y	N	HIV+ / AIDS	Y	N
Blood Transfusion	Y	N	Hospitalizes For Any Reason	Y	N
Cancer/Chemotherapy	Y	N	Kidney Problems	Y	N
Congenital Heart Defect	Y	N	Mitral Valve Prolapse	Y	N
Diabetes	Y	N	Psychiatric Problems	Y	N
Difficulty Breathing	Y	N	Rheumatic / Scarlet Fever	Y	N
Drug / Alcohol Abuse	Y	N	Severe / Frequent Headaches	Y	N
Emphysema / Glaucoma	Y	N	Shingles	Y	N
Epilepsy/Seizures/fainting spells	Y	N	Sickle Cell Disease / Traits	Y	N
Fever Blisters / Herpes	Y	N	Sinus Problems	Y	N
Heart Attack / Stroke	Y	N	Tuberculosis (TB)	Y	N
Heart Murmur	Y	N	Ulcers / Colitis	Y	N
Heart Surgery / Pace Maker	Y	N	Venereal Disease	Y	N

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

Are you allergic to any of the following?

Asprin	Y N	Erythromycin	Y N	Penicillin	Y N
Codeine	Y N	Jewelry / Metals	Y N	Tetracycline	Y N
Dental Anesthetics	Y N	Latex	Y N	Other	Y N

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

Why have you come to the dentist today?
_____
_____

Do you require antibiotics before dental treatment?	Y N
Are you currently in pain?	Y N
Have you ever had a serious / difficult problem associated with any dental work?	Y N
Do you now or have you ever experienced pain / discomfort in your jaw joint?	Y N

(TMJ / TMD)

Do you like your smile? Y N
Do you gums bleed? Y N
Have you ever had periodontal disease? Y N
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 responsibility to inform this office of any changes in medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my information consent.

Signature: _____ Date: _____
Payment is due in full at time of treatment unless prior arrangements have been approved.

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I verbally reviewed the medical / dental information above with the patient named herein.

Initials: _____ Date: _____

Doctors Comments: _____
_____
_____