

Welcome To Flushing Family Dentistry!

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

Date: _____
Name: _____ Dr./Mr./Mrs./Ms.
I prefer to be called: _____ Sex: M F
Birthdate: ___/___/___ Age: ___ SS#: _____
Home Address: _____
City: _____ State: _____ Zip: _____
E-mail: _____
 Single Married Divorced Widowed Separated
Home #: _____ Cell #: _____
Work #: _____ Ext: _____
Employer: _____
Employer Address: _____
Occupation: _____
Best time and place to reach you: _____
Whom may we thank
for referring you? _____
Previous Dentist: _____
Last Visit: _____

2. Spouse Information

His/Her Name: _____
Birthdate: ___/___/___ SS#: _____
Work #: _____ Ext: _____
Person responsible for account: _____
Relation: _____ SS#: _____
Billing Address: _____
Work #: _____ Home #: _____

3. Insurance Coverage

PRIMARY

Dental Coverage: Yes No
Ins. Co. Name: _____
Ins. Co. Address: _____
Ins. Co. Phone: _____ Group #: _____
Insured's Name: _____
Relation: _____ SS#: _____
Birthdate: ___/___/___ Employer: _____

SECONDARY

Dental Coverage: Yes No
Ins. Co. Name: _____
Ins. Co. Address: _____
Ins. Co. Phone: _____ Group #: _____
Insured's Name: _____
Relation: _____ SS#: _____
Birthdate: ___/___/___ Employer: _____

5. Emergency Contact

In case of emergency, is there someone nearby we can contact?
Name: _____
Relation: _____ Home #: _____
Work #: _____ Cell #: _____

6. Medical History

Do you have a personal physician? Yes No
Physician: _____
Phone: _____ Last Visit: ___/___/___
Currently under care? Y N *Continued on back* →

6. Medical History

Your current physical health is: Good Fair Poor

Are you taking any prescription/over-the-counter or herbal supplemental drugs? Y N

Please list each one: _____

Have you ever taken Phen-Fen (Redux or Pondimin)? Y N

For Women: Are you taking birth control pills? Y N

Are you pregnant? Y N Week # _____

Are you nursing? Y N

Have you ever had any of the following diseases or medical conditions?

Heart Problems/Conditions	Y	N
Blood Disorders (bleeding problems)	Y	N
Blood Transfusions	Y	N
High Blood Pressure	Y	N
Stroke	Y	N
Cancer/Chemotherapy	Y	N
Radiation Therapy	Y	N
Diabetes	Y	N
Epilepsy/Seizures	Y	N
Fainting Spells	Y	N
Artificial Joints/Valves	Y	N
Hepatitis	Y	N
HIV/AIDS	Y	N
Tuberculosis	Y	N
Psychiatric Problems	Y	N
Acid Reflux/GERD	Y	N
Liver/Kidney problems	Y	N

Please explain/list any serious medical conditions that you have ever had:

Do you smoke/use tobacco in any form? Y N Previously but quit
 Do you drink alcohol? Never Occasionally Weekly Daily
 Do you use illicit drugs? Never Occasionally Weekly Daily
 What type? _____

Are you allergic to any of the following?

Y N Aspirin	Y N Erythromycin	Y N Ibuprofen
Y N Codeine	Y N Jewelry/Metals	Y N Penicillin
Y N Tetracycline	Y N Local Anesthesia	Y N Latex

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

7. 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 had a serious/difficult problem associated with past 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? Y N

Would you like whiter teeth? Y N

Would you like fresher breath? Y N

How many times a week do you floss? _____

How many times a day do you brush? _____

Type of bristles? Soft Medium Hard

Do you grind/clinch your teeth? Yes No

Do you snore or have sleep apnea? Yes No

8. Informed Consent

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 according to HIPAA regulations and it is my responsibility to inform this office of any changes in my medical status.

I also understand that if this office accepts my dental insurance, I am responsible for payment of my co-pay in full for services rendered the day of service. I also understand that I am responsible for payment of any deductibles and payments that my insurance does not cover.

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: _____

OFFICE USE ONLY

Medical / Dental information above has been verbally reviewed with the patient named herein. Initials: _____ Date: _____

Comments: _____

Medical History Update:

1. Date: _____	Comments: _____	Initials: _____
2. Date: _____	Comments: _____	Initials: _____
3. Date: _____	Comments: _____	Initials: _____