



**Welcome to Our Office —Tell Us About Yourself**

Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
First MI Last

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Number you can be reached during day (circle one):	Home Phone	Your preference for appointment Confirmation (circle one)?	Email	Home Phone
	Cell Phone			Cell Phone
	Work Phone			Work Phone

Marital Status:  Single     Married     Divorced     Widowed     Domestic Partner

How did you hear about our office?

**Insurance—Primary** (Please update if we have not already collected this information)

Subscriber Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

Subscriber Employer: \_\_\_\_\_ Subscriber SSN / ID: \_\_\_\_\_ Insurance Carrier: \_\_\_\_\_

Insurance Phone Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

**Insurance—Secondary** (Please update if we have not already collected this information)

Subscriber Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

Subscriber Employer: \_\_\_\_\_ Subscriber SSN / ID: \_\_\_\_\_ Insurance Carrier: \_\_\_\_\_

Insurance Phone Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

**Assignment and Release (sign only if Insured)**

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Windsor Family Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: \_\_\_\_\_

Relationship: \_\_\_\_\_ Date: \_\_\_\_\_

**Medical History**

Date: \_\_\_\_\_

To be completed every 2 years

Do you have a Primary Physician? Yes / No	Physician's Name:	Physician's Phone:	Date of Last Visit:
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Your current physical health is: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	Do you use tobacco in any form? Yes / No (Circle which applies) Cigarettes or Smokeless
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Are you currently under a physician's care? Yes / No	Please Explain:
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Have you had any metal rods, pins or implants placed? Yes / No	Are you taking any medications? Yes / No	Please list each one: _____
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Have you had any surgical procedures? Yes / No	Please list each one: _____
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Yes	No	Conditions	Yes	No	Conditions	Yes	No	Conditions
		Abnormal Bleeding			Gag Reflex			Sickle Cell Disease
		Alcohol Abuse			Glaucoma			Sinus Problems
		Allergies			HIV + AIDS			Stroke
		Anemia			Heart Attack			Thyroid Problems
		Angina Pectoris			Heart Murmur			Tuberculosis
		Arthritis			Heart Surgery			Ulcers
		Artificial Heart Valve			Hemophilia			
		Asthma			Hepatitis (circle) A / B / C	Yes	No	Allergies
		Blood Transfusion			High Blood Pressure			Aspirin
		Cancer			Joint Replacement			Codeine
		Chemotherapy			Kidney Problems			Dental Anesthetics
		Claustrophobia			Liver Disease			Erythromycin
		Colitis			Low Blood Pressure			Jewelry
		Congenital Heart Defect			Mitral Valve Prolapsed			Latex
		Diabetes			Osteoporosis			Metals
		Difficulty Breathing			Pace Maker			Penicillin
		Drug Abuse			Psychiatric Problems			Tetracycline
		Emphysema			Radiation Therapy			
		Epilepsy			Rheumatic Fever	Yes	No	<b>If Female, Please Answer</b>
		Fainting Spells			Seizures			Are you taking Birth Control Pills?
		Fever Blisters			Sexually Transmitted Disease			Are you pregnant? # of wks _____
		Frequent Headaches			Shingles			Are you nursing?

**Doctor's Comments:**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Dental History

How may we help you today?		
Your current dental health is: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor		
Do you require antibiotics before dental treatment? Yes / No Reason: _____		
Are you currently in pain? Yes / No	Have you ever had gum Or Periodontal Treatment? Yes / No	Do your gums bleed? Yes / No
Do you now or have you had any pain/discomfort in your jaw joint (TMJ)? Yes / No	Are you under stress new job, moving, relationships? Yes / No	Have you lost any teeth? Yes / No
Do you like your smile? Yes / No	Is there anything you would like to change about your smile? Yes / No	Are you happy with the color of your teeth? Yes / No
How many times do you: Floss / week? Brush / day?	When was your last dental cleaning?	Are your teeth sensitive to hot, cold or anything else? Yes / No
Have you ever had a serious/difficult problem with any previous dental work? Yes / No	Have you ever had any unfavorable dental experience? Yes / No	
How would you rate your level of dental anxiety? None 0 2 4 6 8 10 High	When was your last dental visit?	How can we accommodate you during your dental visit?

Windsor Family Dentistry offers a wide variety of services to enhance and keep your smile beautiful.

Smile Makeover / Veneers	Extractions / Wisdom Teeth	Night / Sport Guards
Implants	Partials / Dentures	Teeth Whitening
Sedation	Crown and Bridge	

Nearest relative not living with you:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

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 my medical status.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_