ADULT FORM

Reed Family 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 take care fo you.

1/ABOUT YOU

TODAY'S DATE

LEGAL NAME | PREFERRED NAME | SEX: ☐ Male ☐ Female

DATE OF BIRTH / / | AGE | SOCIAL SECURITY NUMBER | EMAIL ADDRSS

ADDRESS

CITY | STATE | ZIPCODE

STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

HOME PHONE | CELL PHONE | WORK NUMBER | EXT

EMPLOYER | EMPLOYER'S ADDRESS

HOW LONG HAVE YOU BEEN EMPLOYED HERE? | OCCUPATION

WHERE AND WHEN ARE THE BEST TIMES TO REACH YOU?

WHOM MAY WE THANK FOR REFERRING YOU? | OTHER FAMILY MEMBERS SEEN BY US

PREVIOUS / PRESENT DENTISTS | LAST VISIT DATE

2/SPOUSE INFORMATION

HIS OR HER NAME | SPOUSE'S EMPLOYER | WORK NUMBER | EXT

SOCIAL SECURITY NUMBER | DATE OF BIRTH / /

3/ACCOUNT INFORMATION

PERSON RESPONSIBLE FOR THE ACCOUNT | WORK NUMBER | EXT

HOME NUMBER | BILLING ADDRESS

RELATION | SOCIAL SECURITY NUMBER

EMPLOYER

4/PRIMARY DENTAL INSURANCE

INSURANCE COMPANY NAME

INSURANCE COMPANY ADDRESS

INSURANCE COMPANY PHONE

GROUP # (PLAN, LOCAL OR POLICY #)

INSURED'S NAME

RELATION

INSURED'S DATE OF BIRTH

INSURED'S ID #

INSURED'S EMPLOYER

5/SECONDARY DENTAL INSURANCE

INSURANCE COMPANY NAME

INSURANCE COMPANY ADDRESS

INSURANCE COMPANY PHONE

GROUP # (PLAN, LOCAL OR POLICY #)

INSURED'S NAME

RELATION

INSURED'S DATE OF BIRTH

INSURED'S ID #

INSURED'S EMPLOYER

6/MEDICAL HISTORY

DO YOU HAVE A PERSONAL PHYSICIAN: ☐ Yes ☐ No

PHYSICIAN'S NAME

PHONE NUMBER

LAST VISIT DATE

ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN? ☐ Yes ☐ No

PLEASE EXPLAIN

YOUR CURRENT PHYSICAL HEALTH: ☐ Good ☐ Fair ☐ Poor

DO YOU SMOKE OR USE TOBACCO IN ANY FORM? ☐ Yes ☐ No

ARE YOU TAKING ANY PRESCRIPTION / OVER-THE-COUNTER OR HERBAL SUPPLEMENT DRUGS? ☐ Yes ☐ No

PLEASE EXPLAIN

HAVE YOU EVER TAKEN FOSAMAX OR ANY OTHER BISPHOSPHONATE? ☐ Yes ☐ No

HAVE YOU EVER TAKEN PHEN-FEN? ☐ Yes ☐ No

ARE YOU USING A PRESCRIBED METHOD OF BIRTH CONTROL? ☐ Yes ☐ No

ARE YOU PREGNANT? ☐ Yes ☐ No

ARE YOU NURSING? ☐ Yes ☐ No

6/MEDICAL HISTORY *(continued)*

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

Y	N		Y	N		Y	N	
☐	☐	Abnormal bleeding	☐	☐	Frequent Headaches	☐	☐	Lupus
☐	☐	Alcohol / Drug Abuse	☐	☐	Glaucoma	☐	☐	Mitral Valve Prolapse
☐	☐	Anemia	☐	☐	Hay Fever	☐	☐	Pacemaker
☐	☐	Arthritis	☐	☐	Heart Attack	☐	☐	Physciatric Problems
☐	☐	Artificial Bones / Joints	☐	☐	Heart Murmur	☐	☐	Radiation Treatment
☐	☐	Asthma	☐	☐	Heart Surgery	☐	☐	Rheumatic / Scarlet Fever
☐	☐	Blood Transfusion	☐	☐	Hemophilia	☐	☐	Seizures
☐	☐	Cancer / Chemotherapy	☐	☐	Hepatitis	☐	☐	Shingles
☐	☐	Colitis	☐	☐	Herpes / Fever Blisters	☐	☐	Sickle Cell Disease
☐	☐	Congenital Heart Defect	☐	☐	High Blood Pressure	☐	☐	Sinus Problems
☐	☐	Diabetes	☐	☐	HIV+ / AIDS	☐	☐	Stroke
☐	☐	Difficulty Breathing	☐	☐	Hospitalized for any reason	☐	☐	Thyroid Problems
☐	☐	Emphysema	☐	☐	Kidney Problems	☐	☐	Tuberculosis (TB)
☐	☐	Epilepsy	☐	☐	Liver Disease	☐	☐	Ulcers
☐	☐	Fainting Spells	☐	☐	Low Blood Pressure	☐	☐	Veneral Disease

PLEASE EXPLAIN

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Y	N		Y	N		Y	N	
☐	☐	Aspirin	☐	☐	Erythromycint	☐	☐	Penicillin
☐	☐	Codeine	☐	☐	Jewelry / Metals	☐	☐	Tetracycline
☐	☐	Dental Anesthetics	☐	☐	Latex	☐	☐	Other

PLEASE EXPLAIN

7/EMERGENCY CONTACT

HIS/HER NAME

RELATION

WORK NUMBER

HOME NUMBER

8/DENTAL HISTORY

WHY HAVE YOU COME TO THE DENTIST TODAY?

HAS YOUR DOCTOR TOLD YOU THAT 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 OR HAVE YOU EXPERIENCED PAIN / DISCOMFORT IN YOUR JAW JOINT (TMJ / TMD)? ☐ Yes ☐ No

YOUR CURRENT 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? HOW MANY TIMES 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 of confidence and it is my responsibility to inform this office of any change in my medical status. I authorize the dental staff to perofrm any necessary dental services that I may need during diagnosis and treatment with my informed consent.

SIGNATURE DATE

Thank you for filling out this form completely it will enable us to help you more effectively. If you have a question at any time, please ask us. We are happy to help.

Our office isHIPPA compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

A/OFFICE USE ONLY

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

DOCTOR'S COMMENTS

B/MEDICAL HISTORY UPDATE

DATE	COMMENTS	SIGNATURE
DATE	COMMENTS	SIGNATURE
DATE	COMMENTS	SIGNATURE