Biltmore COMMONS DENTAL CARE

WELCOME TO OUR DENTAL FAMILY

Patient Information

Name: _____ Birthdate: _____

Address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Work phone: _____ Email: _____

Sex: UM OF Marital status: O Single O Married O Divorced O Separated O Partnership O Widowed

Employer or School: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Spouse, partner or parent name: _____

Person to contact in case of an emergency: _____ Phone: _____

How did you learn about our practice or whom may we thank for referring you? _____

Who is responsible for your account and payment? (if different from previous listing): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email: _____ Birthdate: _____

Dental Insurance

Insurance company: _____ Phone X _____

Subscriber's Social Security # _____ Group # _____ ID # _____

Address: _____ City: _____ State: _____ Zip: _____

Whose name is this insurance under? _____

Employer offering this insurance? _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Scondary Dental Insurance

Insurance company: _____ Phone # _____

Subscriber's Social Security # _____ Group # _____ ID # _____

Address: _____ City: _____ State: _____ Zip: _____

Whose name is this insurance under? _____

Employer offering this insurance? _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Dental History

Reason for today's visit: _____

Date of last dental care visit: _____ Date of last dental x-rays: _____

Former dentist's name: _____ Phone: _____

Check if you have any problem with the following: _____

O Bad breath
O Bleeding gums
O Clicking or popping jaw
O Food collection between certain teeth
O Grinding teeth
O Loose teeth or broken fillings
O Periodontal treatment
O Sensitivity to any of the following: cold, hot, sweets
O Sensitivity when biting
O Sores or growth in your mouth

How often do you floss? _____ How often do you brush? _____

Medical History

Your physician: _____ Date of last visit: _____

Have you ever taken any of the groups of drugs collectively referred to as "fen-phen"? O Yes O No

Have you had any serious illnesses or operations? O Yes O No

If yes, describe: _____

Have you ever had a blood transfusion? O Yes O No

If yes, give approximate dates: _____

Women: are you pregnant? O Yes O No

Are you nursing? O Yes O No

Are you taking birth control? O Yes O No

Check if you have or have had any of the following:

❍ Anemia	O Fainting	O Radiation treatment
❍ Arthritis, rheumatism	O Glaucoma	O Respiratory disease
❍ Artificial heart valves	O Headaches	O Rheumatic fever
❍ Artificial joints, pins, etc.	O Heart murmur	O Scarlet fever
❍ Asthma	O Heart problems	O Sexually transmitted disease
❍ Bleeding abnormally	O Hemophilia	O Stroke
❍ Blood disease	O Hepatitis	O Swelling of feet or ankles
❍ Cancer	O High blood pressure	O Thyroid problems
❍ Chemical dependency	O HIV AIDS	O Tobacco use
❍ Chemotherapy	O Jaw pain	O Tonsillitis
❍ Circulatory problems	O Kidney disease	O Tuberculosis
❍ Congenital heart lesions	O Liver disease	O Ulcer
❍ Diabetes	O Mitral valve prolapse	O Latex allergy
❍ Epilepsy	O Pacemaker	

List medications you are currently taking and the correlating diagnosis:

Medication	**Diagnosis**

Please list any allergies you may have:

Allergy	**Allergy**

To the best of my knowledge, the above information is complete and correct.
I understand that it is my responsibility to inform my doctor if I or my minor child has a change in health.

_____ _____

Patient or Guardian *Signature* *Date*