



**Pospisil**  
Family Dentistry

# Welcome

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: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

**Name:** \_\_\_\_\_  
LAST FIRST MI MR MRS MS DR

I Prefer to be called: \_\_\_\_\_  Male  Female

Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ SS#: \_\_\_\_\_

Home Address: \_\_\_\_\_  
APT/CONDO #

\_\_\_\_\_ CITY STATE ZIP

Single  Married  Divorced  Widowed  Separated

Hm #: (\_\_\_\_) \_\_\_\_\_ Pager/Cell #: \_\_\_\_\_

Wk #: (\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_ DL #: \_\_\_\_\_

**Employer:** \_\_\_\_\_

Employer's Address: \_\_\_\_\_

How long there? \_\_\_\_\_ Occupation: \_\_\_\_\_

When and where are the best times to reach you? \_\_\_\_\_

Whom may we Thank for referring you? \_\_\_\_\_

Other family members seen by us: \_\_\_\_\_

Previous/Present Dentist: \_\_\_\_\_  
(Please Circle)

Last Visit Date: \_\_\_\_\_

**INSURANCE**

**Primary Insurance**

Dental Coverage?  Yes  No

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone #: (\_\_\_\_) \_\_\_\_\_

Group # (Plan, Local or Policy#) \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Insured's Birthdate: \_\_\_/\_\_\_/\_\_\_ Insured's ID #: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

**Secondary Insurance**

Dental Coverage?  Yes  No

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone #: (\_\_\_\_) \_\_\_\_\_

Group # (Plan, Local or Policy#): \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Insured's Birthdate: \_\_\_/\_\_\_/\_\_\_ Insured's ID #: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

**Neighbor or Relative not living with you.**

His/Her Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Wk #: (\_\_\_\_) \_\_\_\_\_ Hm #: (\_\_\_\_) \_\_\_\_\_

Home Address: \_\_\_\_\_

\_\_\_\_\_ CITY STATE ZIP

**SPOUSE INFORMATION**

His/Her Name: \_\_\_\_\_

Employer: \_\_\_\_\_

Wk #: (\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_ SS #: \_\_\_\_\_

Birthdate: \_\_\_/\_\_\_/\_\_\_ DL#: \_\_\_\_\_

**Person Responsible for Account:** \_\_\_\_\_

Wk #: (\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_ Hm #: (\_\_\_\_) \_\_\_\_\_

Billing Address: \_\_\_\_\_

Relation: \_\_\_\_\_ SS #: \_\_\_\_\_

Employer: \_\_\_\_\_ DL #: \_\_\_\_\_

**MEDICAL HISTORY**

**Do you have a personal physician?**  Yes  No

Physician's Name: \_\_\_\_\_

Phone #: (\_\_\_\_) \_\_\_\_\_ Date of last visit: \_\_\_\_\_

Are you currently under the care of a physician?  Yes  No

Please Explain: \_\_\_\_\_

CONTINUED ON BACK

## MEDICAL HISTORY continued

**Your current physical health is:**  Good  Fair  Poor  
 Do you smoke or use tobacco in any other form?  Yes  No  
 Have you had any metal rods, pins, implants?  Yes  No  
 Are you taking any prescription/over-the-counter or herbal supplement drugs?  Yes  No  
 Please list each one: \_\_\_\_\_  
 \_\_\_\_\_  
 Have you ever taken Fosamax, or any other bisphosphonate?  Yes  No  
 Have you ever taken Phen-Fen?  Yes  No

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

Y N Abnormal Bleeding	Y N Herpes / Fever Blisters
Y N Alcohol / Drug Abuse	Y N High Blood Pressure
Y N Anemia	Y N HIV+ / AIDS
Y N Arthritis	Y N Hospitalized for Any Reason
Y N Artificial Bones / Joints / Valves	Y N Kidney Problems
Y N Asthma	Y N Liver Disease
Y N Blood Transfusion	Y N Low Blood Pressure
Y N Cancer / Chemotherapy	Y N Lupus
Y N Colitis	Y N Mitral Valve Prolapse
Y N Congenital Heart Defect	Y N Osteoporosis / Paget's Disease
Y N Diabetes - Type _____	Y N Pacemaker
Y N Difficulty Breathing	Y N Psychiatric Problems
Y N Emphysema	Y N Radiation Treatment
Y N Epilepsy	Y N Rheumatic / Scarlet Fever
Y N Fainting Spells	Y N Seizures
Y N Frequent Headaches	Y N Shingles
Y N Glaucoma	Y N Sickle Cell Disease / Traits
Y N Hay Fever	Y N Sinus Problems
Y N Heart Attack	Y N Stroke
Y N Heart Murmur	Y N Thyroid Problems
Y N Heart Surgery	Y N Tuberculosis (TB)
Y N Hemophilia	Y N Ulcers
Y N Hepatitis - Type _____	Y N Venereal Disease

**Please list any past serious medical conditions and hospitalizations:**  
 \_\_\_\_\_  
 \_\_\_\_\_

### Are you allergic to any of the following?

Y N Aspirin	Y N Erythromycin	Y N Tetracycline
Y N Codeine	Y N Latex	Y N Other
Y N Dental Anesthetics	Y N Penicillin	

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

**For Women:** Are you using a prescribed method of birth control?  Yes  No

Are you pregnant?  Yes  No Week # \_\_\_\_\_

Are you nursing?  Yes  No

### For Minors:

Is the use of Nitrous Oxide permitted?  Yes  No  
 If X-rays are necessary, are they permitted?  Yes  No  
 Is the use of topical fluoride treatment permitted?  Yes  No

## DENTAL HISTORY

**Why have you come to the dentist today?** \_\_\_\_\_  
 \_\_\_\_\_

Do you require antibiotics before dental treatment?  Yes  No  
 Reason if yes \_\_\_\_\_

Are you currently in pain?  Yes  No

Have you ever had serious/difficult problem associated with any previous dental work?  Yes  No

Have you ever had gum treatment?  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?  Yes  No Do your gums ever bleed?  Yes  No

How many times a week do you floss? \_\_\_\_\_ a day do you brush? \_\_\_\_\_

Type of bristles?  Soft  Medium  Hard

How long do you use a toothbrush before replacing it? \_\_\_\_\_

Are your teeth sensitive to heat, cold or anything else? \_\_\_\_\_

Have you lost any teeth?  Yes  No If yes, why? \_\_\_\_\_

**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 charges in my medical status.**

**Payment is due in full at the time of treatment**  
 unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature of Patient or Guardian \_\_\_\_\_

Date \_\_\_\_\_

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

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I verbally reviewed the medical/dental information above with the patient and herein. \_\_\_\_\_

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

### MEDICAL HISTORY UPDATE

I have read my medical history dated \_\_\_\_\_ and confirmed that it states past and present medical conditions.

Signature \_\_\_\_\_

Date \_\_\_\_\_

I have read my medical history dated \_\_\_\_\_ and confirmed that it states past and present medical conditions.

Signature \_\_\_\_\_

Date \_\_\_\_\_

I have read my medical history dated \_\_\_\_\_ and confirmed that it states past and present medical conditions.

Signature \_\_\_\_\_

Date \_\_\_\_\_