Welcome to Commerce Drive Dental Group! Today's Date ____/____/____

The benefits of a healthy smile are immeasurable, and our goal is to help you maintain maximum oral health. Please fill out this confidential form as accurately as possible. Feel free to ask us any questions you may have.

If unable to keep your appointment, please give a 24 hour notice to avoid a missed appointment fee.

ABOUT YOU

First Name/Middle Int: _____
Last Name: _____
SS #: _____ Male / Female
Birthdate: ____/____/____ Age: _____
Home address: _____
_____
Phone: _____ _____
Home **Work**
Cell phone: _____
Email address: _____
Where and when is it best to reach you?
_____
Employer: _____
How long there? _____ Occupation: _____
_____
Single / Married / Separated / Divorced / Widowed
Spouse's name: _____
Spouse's SS#: _____
Spouse's birthdate: ____/____/____
Spouse's employer: _____

Other family members seen by us _____
_____
Whom may we thank for referring you to our office? _____
Relationship: _____

EMERGENCY CONTACT

Name: _____
Relation: _____
Phone: _____ _____
Home **Work**
Cell phone: _____
Email address: _____

RESPONSIBLE FOR ACCOUNT

Name: _____
Relation: _____
Phone : _____ _____
Home **Work**
Cell phone: _____

DENTAL INSURANCE

Primary Company _____
Secondary Company _____

I understand that in the case operative work is recommended, I will be given treatment fees and estimated insurance coverage. I will be responsible for all fees not covered by insurance at the time treatment is completed.

Why have you come to our office today? _____
_____

MEDICAL HISTORY

Y N Have you been under the care of a physician within the past two years? Please explain.
_____
_____
_____
Primary physician _____
Physician's phone # _____
Y N Are you taking any prescription or over-the-counter drugs? Please list each drug and the reason for taking it.

Drug	Condition
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Are you allergic to any of the following?

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

Please list any other medications you are allergic to:
_____
_____

For Women Only:
Y N Are you taking birth control pills?
Y N Are you pregnant? Due date: _____
Y N Are you nursing?

Please turn over for additional information.

Please CIRCLE any of the following medical problems or diseases you have ever had:

1. Heart Attack
   Date(s) _____
2. Heart Surgery / Pacemaker
3. Heart Murmur / Mitral Valve Prolapse
4. Congenital Heart Defect
5. Heart Valves **Repaired / Replaced**
6. High / Low Blood Pressure
7. Abnormal Bleeding / Hemophilia / Anemia
8. Blood Transfusions
9. Diabetes Type I or Type II
10. Stroke / Severe or Frequent Headaches
11. Epilepsy / Seizures / Fainting Spells
12. Glaucoma
13. Sinus Problems / Difficulty Breathing
14. Asthma Inhaler(s) **Y / N** / Lung problems
15. Tuberculosis (TB)
16. Hepatitis Type
17. HIV +/ AIDS
18. Kidney Problems
19. Ulcers / Colitis
20. Artificial Joints (specify):_____
    _____
21. Cancer / Chemotherapy / Radiation Tx.
22. Drug / Alcohol Abuse (specify):
    _____
23. Hospitalized for any reason (specify):
    _____
    _____
24. Have you ever taken a prescription medication for bone density? **Y / N**

Please list any serious medical condition(s) that you have ever had:_____
_____

Dental History

Y N Do you brush daily?
Y N Do you floss daily?
Y N Are you currently in pain?
Y N Have you ever had a serious/difficult problem associated with any previous dental work?
Y N Do you now or have you ever experienced any pain in your jaw joint (TMJ/TMD)?
Y N Have you had an injury to your head, face, neck or jaw?
Y N Have you ever been told you snore or have sleep apnea?
Y N Do you clench or grind your teeth while awake or asleep?
Y N Do you do/use any of the following: smokeless tobacco, smoking tobacco, vaping devices? (specify)
_____
Y N Do you want to use nitrous oxide (commonly called laughing gas)?
Y N Are you interested in straightening your teeth with braces (orthodontics)?
Y N Is there anything about your smile you are interested in changing?_____
_____
Y N Have you ever had an upsetting experience in a dental office? _____
_____
Y N Is there anything about your last dental office that you did not like? _____
_____

Please list any questions you might have: _____
_____
_____

The above information I have provided is correct and it is my responsibility to inform this office of any changes in my medical status. I have had full opportunity to read and consider your Notice of Privacy Practices. I understand that, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations. My signature authorizes release of information to process my claim and to other health care providers about my history, examination, diagnosis, and treatment course. In addition, I agree CDDG, its' affiliates and agents may use an automated telephone dialing system and/or pre-recorded messages to contact the wireless number(s) and/or residential lines that I provide to CDDG for appointment and payment purposes. Balances of 60 days and over are subject to 1.5% finance charge.

_____
Signature **Date**

PREMEDICATION

Y N Have you ever premedicated with antibiotics prior to a dental appointment? (specify)

Medication	**Reason**
_____	_____
_____	_____

MEDICAL HEALTH UPDATE – *Please verify and correct any changes in your health status.*

Date	Change	Pt. Initial	Staff Initial	Pulse	Blood Pressure
_____	Y / N	_____	_____	_____	____/____
_____	Y / N	_____	_____	_____	____/____
_____	Y / N	_____	_____	_____	____/____
_____	Y / N	_____	_____	_____	____/____
_____	Y / N	_____	_____	_____	____/____