CONTACT

Patient's Name: _____Preferred Name:_____

Age: _____ Birthdate:___/____/_____ Gender:_____

Address:_____

City:_____ State:____ Zip:_____ Email:_____

Home Phone: _____ Cell Phone: _____ Work Phone:_____

SS#:_____ Marital Status: ☐ Single ☐ Married ☐Divorced ☐Widowed

Employer:_____ Employer's Phone Number: _____

Spouse's Name:_____ Spouse's Cell: _____

Emergency Contact: _____ Relation:_____ Phone Number:_____

Would you like to receive appointment reminders via text message or email? ☐Yes ☐ No

INSURANCE: Do you have dental insurance? ☐Yes ☐ No

If YES, Please give a copy of your current dental insurance(s) card and driver's license to our front desk.

MISSED APPOINTMENT POLICY: Appointments must be rescheduled or cancelled 48 hours before your scheduled appointment. If a scheduled appointment is missed or cancelled prior to 48 hours, a $50 missed appointment fee will be charged.

FINANCIAL OBLIGATION: Your dental insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. The responsibility of payment ultimately lies with the patient, not the insurance company. As a courtesy, we will file a claim on your behalf**. I understand that I am required to pay my "Estimated Patient Portion" and any deductible due, to Fuller Associates Family Dentistry at the time of my visit**. Failure to provide our office with all the information necessary to file your insurance claim will require full payment at the time of service. Any portion of the treatment that the insurance does not cover is the patient's responsibility. I hereby authorize the release of any dental information that is needed to file my insurance. I consent to treatment for myself/family under 18 years old. I have read the following statements and understand that I am responsible for payment in full after 30 days of my treatment, regardless of any delay in payment(s) by my insurance company. I understand that a 1.0% per month charge may be added to my account for any late balance.

By my signature below, I read, acknowledge, and agree to the Missed Appointment Policy and Financial Obligation at Fuller Associates Family Dentistry.

Type Name/Signature: _____ Date:____/____/_____

UPDATE: By initialing today, I verify that I provided Fuller Associates with the most accurate information regarding my health.

Medical History NAME: _____

Have you taken any prescription drugs during the last 6 months or any over the counter medications/ herbal supplements? **Please provide a list.**

_____

_____

_____

Have you ever been told to take antibiotics prior to dental treatment? If yes, why? _____

Do you have any allergies or are made sick by any medication? Please provide a list and the side effects.

_____

Have you had any surgeries and/or hospitalizations?

_____

Have you ever had excessive bleeding requiring special treatment? _____

Have you ever taken drugs by mouth or injection to strengthen bone for conditions such as osteoporosis, multiple myeloma, Paget's disease, breast or prostate cancer? Please list which one and when was the last time taking the prescription/ injection_____

Use of alcohol: ☐ Yes ☐ No // ☐ Daily ☐ Weekly ☐ Monthly Use of recreational drugs: ☐ Yes ☐No
Do you use tobacco? ☐ Yes ☐ No What type of tobacco product? [Juul/ Cigarettes/ Chewing Tobacco/Cigars] How much per day? _____

FEMALES ONLY: Are you pregnant now? ☐ Yes ☐ No // Practicing birth control? ☐ Yes ☐ No // Plan to become pregnant? ☐ Yes ☐ No

Preferred Pharmacy:_____

CHECK ANY OF THE FOLLOWING WHICH YOU HAVE AT THE PRESENT OR HAVE HAD IN THE PAST:

☐ Low Blood Pressure
☐ High Blood Pressure
☐ Heart Disease/Attack
☐ Angina Pectoris
☐ Artificial Heart Valve
☐ Heart Failure
☐ Heart Pacemaker
☐ Stroke
☐ Kidney Problems
☐ Sexually Transmitted Infections (formally known as STD)
☐ Tuberculosis
☐ M.S.
Other:_____

☐ Acid Reflux
☐ Cholesterol
☐ Ulcers
☐ Liver Failure
☐ Hepatitis/ Jaundice
☐ Diabetes Type I or II
☐ Thyroid/ Gland Problems
☐ Seizures/ Epilepsy
☐ Allergies/ Sinus Trouble
☐ Asthma/ Bronchitis
☐ Autism, Diagnosis:_____
☐ Emphysema/ COPD
☐ Chemotherapy

☐ Cancer/Tumors
☐ Radiation Treatment
☐ HIV/AIDS
☐ Anemia
☐ Leukemia
☐ Bruise/ Bleed Easily
☐ Osteoporosis
☐ TMJ/Jaw Problems
☐ Arthritis
☐ Joint Replacements
☐ Sleep Apnea
☐ Scarlet Fever
☐ Excessive Daytime Sleepiness

Dental History

Answers to these questions help us provide safe and effective dental care personalized to your individual needs. All information is kept strictly confidential.

ARE ANY OF YOUR TEETH SENSITIVE TO:	YES	NO
Hot or cold?	☐	☐
Sweets?	☐	☐
Biting or chewing?	☐	☐
Have you noticed any mouth odors or bad taste?	☐	☐
Do you frequently get cold sores?	☐	☐
Do you frequently get oral ulcers?	☐	☐
Do your gums bleed or hurt?	☐	☐
Have you noticed any loose teeth?	☐	☐
Have your teeth shifted over the years?	☐	☐
Does food tend to become caught in your teeth?	☐	☐

DO YOU:		
Drink pop, sports drinks, juice, or energy drinks daily?	☐	☐
Clench/ grind your teeth while awake or asleep? Mouth breathe?	☐	☐
Drink only well water or filtered water?	☐	☐
Hold foreign objects with your teeth (i.e. pencils, nails)? Chew ice often?	☐	☐

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING:		
Clicking or popping of the jaw?	☐	☐
Pain in the jaw joint area near the ear?	☐	☐
Difficulty in opening or closing your mouth?	☐	☐
Headaches, neck aches, or shoulder aches frequently?	☐	☐
Sore muscles in the neck or shoulders?	☐	☐

I WOULD LIKE TO LEARN MORE ABOUT:

☐ Orthodontics ☐ Cosmetic Dentistry ☐ Sedation Dentistry ☐ Implants
☐ Whitening ☐ Bridges ☐ Veneers ☐ Dentures ☐ Other _____

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

What other dental aids do you use? (electric toothbrushes, Waterpik water flosser, soft picks)

_____

Do you have any dental problems that you are aware of now? If yes, please describe.

_____

Do you feel nervous about dental treatment? If yes, what is your biggest concern?

_____

NEW PATIENT ONLY: When was your last dental visit? ___/___/___ Last x-rays? __/___/___
Have you ever had scaling and root planning OR periodontal maintenance? ☐ Yes ☐ No
Name of last dental office: _____ **How did you hear about us?** _____