

WELCOME

Dawn Morehead, DDS, PA.

ABOUT YOU:

Today's Date: ____/____/____

Why have you come to the dentist today? _____

NAME: _____
last first m.i.

(I prefer to be called: _____)

HOME ADDRESS: _____

PO Box

Physical Address (Required)

city state zip

Phone Numbers:

Hm#: _____ Cell/Other#: _____

Wk#: _____ Ext: _____

When & where are the best times to reach you?

Would you be available for short notice appointments? Y N

Birthdate: ____-____-____ SS#: ____-____-____

Male Female Age: _____
 Single Married Divorced Widowed Separated

Employer: _____

Do you have Dental Insurance? Yes No

Whom may we thank for referring you? _____

Other family members seen by us: _____

Last Dental Cleaning: 0-6mos 6mos-1yr 1-2yr over 2yrs

PERSON RESPONSIBLE FOR ACCOUNT: (if other than self)

NAME: _____
last first m.i.

Address: _____
street apt./box #

city state zip

Wk#: _____ Ext: _____ Hm#: _____

MEDICAL HISTORY:

Physician's Name: _____

Phone #: _____ Date of last visit: _____

FOR WOMEN: Are you taking birth control pills? yes no
Are you **PREGNANT**? yes no week # _____
Are you nursing? yes no

Are you **ALLERGIC** to any of the following? Yes No
 Aspirin Codeine Penicillin
 Erythromycin Tetracycline Latex
 Dental Anesthetics Any Metals Red Dye
Please list **OTHER DRUG ALLERGIES**: _____

Have you ever had any of the following: Yes No

- | | |
|---|---|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Broken jaw | <input type="checkbox"/> Ulcers/Colitis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Drug/Alcohol Abuse | <input type="checkbox"/> Emphysema/Glaucoma |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Asthma/Arthritis |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> HIV+/AIDS | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Epilepsy/Seizures/Fainting | <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> Artificial Joints/Valves | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Gum Disease |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Smoke/Tobacco Use |
| <input type="checkbox"/> Mitral Valve Prolapse | |
| <input type="checkbox"/> Heart Problems/Surgery/Pacemaker | |
| <input type="checkbox"/> Heart Attack (if so, when: _____) | |
| <input type="checkbox"/> Cancer/Chemotherapy (if so, when: _____) | |
| <input type="checkbox"/> Other health problems: _____ | |
| <input type="checkbox"/> Any recent surgery: _____ | |

MEDICATIONS you are taking:

- I understand that insurance is a contract between me & my insurance company. I am responsible for any fees not covered by insurance.
- PAYMENT IS DUE AT TIME OF SERVICE.

signature

date