WELCOME

Arrowhead Dentistry John H. Upton, Jr., DDS, P.C. MAGD
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About You

Today's Date_____ E-mail Address_____

Name_____ I prefer to be called_____
(Last, First, M.I.) Mr. Mrs. Ms.

Birthdate ___/___/___ Age_____ Social Security #_____ ____Male ____ Female

____ Single ____ Married ____Widowed ____Divorced

Home Address_____
Street City State Zip
Home/Cell Phone_____ Work _____ Other_____

Preferred Method of Contact: ___Home/Cell Phone ___Work Phone ___Text ___ E-Mail

Who may we thank for referring you?_____

Other family members seen by us_____

Employer_____ Occupation_____

Employer's Address_____

Neighbor or Relative not living with you
Name_____ Contact Phone #_____

Address_____

Spouse Information

Name_____ Birthdate ___/___/___ SSN#_____

Employer_____ Phone #_____

Insurance Information

Primary Insurance Dental Coverage ___Yes ___No Orthodontic Coverage ___Yes ___No

Ins. Co. Name_____ Policy #_____
Ins. Co. Address_____ Phone_____
Insured's Name_____ SSN_____ DOB____/____/___
Insured's Employer_____ Employer's Address_____

Secondary Insurance Dental Coverage ___Yes ___No Orthodontic Coverage ___Yes ___No
Ins. Co. Name_____ Policy #_____
Ins. Co. Address_____ Phone_____
Insured's Name_____ SSN# _____ DOB____/____/____
Insured's Employer_____ Employer's Address_____

Dental History

Why have you come to the dentist today?_____

Previous Dentist_____ Date of last visit _____

Are you currently in pain? ___ Yes ___No
Do you require antibiotics before dental treatment? ___ Yes ___No
Your current dental health is ___ Good ___ Fair ___ Poor
Do you floss daily? ___ Yes ___No Do you brush daily? ___Yes ___No
Type of bristles on your toothbrush ___ Hard ___Medium ___Soft
Do your gums ever bleed? ___Yes ___ No Itch? ___Yes ___No
Are your teeth sensitive to heat, cold or anything else? ___Yes ___ No
Do you have mobility in your teeth? ___Yes ___ No
Do you still have wisdom teeth? ___Yes ___ No
Do you have or have you ever experienced
pain or discomfort in your jaw joint? ___ Yes ___ No
Would you like fresher breath? ___ Yes ___ No
Are you happy with your smile? ___ Yes ___ No
If not, what would you like to change?_____

Medical History

Are you currently under the care of a physician? ___ Yes ___ No
If yes, please explain _____
_____
Name of personal physician_____:_____
Address_____ Phone _____
Do you smoke or use tobacco in any form? ___ Yes ___ No
Have you ever taken Phen-Fen, Redux, or Pondimim? ___ Yes ___ No
For Women: Are you taking birth control pills? ___ Yes ___ No
Are you pregnant? ___ Unsure ___ Yes ___ No
If yes, week #_____ Nursing? ___ Yes ___ No

Do you or have you experienced the following:

Y N Abnormal bleeding	Y N Colitis	Y N Hay Fever	Y N Liver Disease	Y N Shingles
Y N Alcohol Abuse	Y N Congenital Heart Defect	Y N Headaches	Y N Low Blood Pressure	Y N Sickle Cell Disease
Y N Anemia	Y N Diabetes	Y N Heart Attack	Y N Lupus	Y N Sinus Problems
Y N Arthritis	Y N Difficulty Breathing	Y N Heart Murmur	Y N MVP	Y N Steroid Therapy
Y N Artificial bones/joints	Y N Drug Abuse	Y N Heart Surgery	Y N Pacemaker	Y N Stroke
Y N Artificial Valves	Y N Emphysema	Y N Hemophilia	Y N Persistent Cough	Y N Thyroid Problems
Y N Asthma	Y N Epilepsy	Y N Hepatitis	Y N Psychiatric Problems	Y N Tonsillitis
Y N Blood Transfusion	Y N Ever Hospitalized	Y N Herpes	Y N Radiation Treatment	Y N Tuberculosis
Y N Cancer	Y N Fainting Spells	Y N HBP	Y N Rheumatic Fever	Y N Ulcers
Y N Chemotherapy	Y N Fever Blisters	Y N HIV+/AIDS	Y N Scarlet Fever	Y N Venereal Disease
Y N Chicken Pox	Y N Glaucoma	Y N Kidney Disease	Y N Seizures	

Please list any serious medication conditions you have experienced_____
_____

Are you taking any prescription/over the counter drugs Y N. If yes, please list _____
_____

Are you allergic to any of the following:

Aspirin	Y N	Latex	Y N	Barbiturates	Y N
Codeine	Y N	Sedatives	Y N	Dental Anesthetics	Y N
Erythromycin	Y N	Tetracycline	Y N	Jewelry/Metals	Y N
Penicillin	Y N	Sulfa Drugs	Y N		

Other (Please list anything additional that causes allergic reactions)_____

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my personal or medical status. I authorize the dental staff to perform the necessary services I may need. I assign the Doctor all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover. I have received a copy of this office's Notice of Privacy Practices.

Signature_____ Date_____