West Madison Dental

Stuart J. McCormick DDS

Welcome

www.westmadisondental.com

Your dental health and happiness are the primary goals for our team. Please accurately complete this confidential form to help these goals become a reality for you!

1 About You

Today's Date: _____

Name: _____
Last First Middle Initial

❑ Male ❑ Female I prefer to be called: _____

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Birth Date: ___/___/___ SS #: _____

Home Address: _____

_____
City State Zip

Home Telephone #: _____

Work #: _____ Ext: ____ Cell #: _____

Email Address: _____

Employer: _____

Employer's Address: _____

Occupation: _____ How Long Held: _____

Best Time/Place to Reach: _____

Previous/Present Dentist: _____
(please circle)

Date of Last Dental Visit: _____

2 Spouse Information

Name: _____
Last First Middle Initial

Employer: _____

Work #: _____ Ext.: _____

Birth Date: _____ SS #: _____

3 Referral Information

Are other family members currently seen in our office?

❑ No ❑ Yes *location*: _____

name of account holder: _____

How did you hear about our office? _____

❑ Family/Friends/Co-Workers *name*: _____

❑ Internet *website*: _____

❍ Angie's List ❍ Google Places ❍ Mynewsmile ❍ Website Search

❑ Direct Mail Piece

❑ Newspaper Advertisement ❑ Television ❑ Magazine

❑ Insurance Plan *name*: _____

❑ Other *explain*: _____

4 Primary Dental Insurance

Insurance Co.: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birth Date: __/__/__ ID/SS #: _____

Insured's Employer: _____

Secondary Dental Insurance

Insurance Co.: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birth Date: __/__/__ ID/SS #: _____

Insured's Employer: _____

5 Consent

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care. I consent to the dentist's use of and disclosure of my records (or my child's records) to carry out treatment, obtain payment, and for those activities and health care operations that are related to treatment or payment.

I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.

_____

_____

My consent to disclosure of records shall be effective until I revoke it in writing. I authorize payment directly to the dentist or dental group on insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid by my dental care payer. I attest to the accuracy of the information on this page.

_____

Signature of Patient (or Guardian) Date

OVER →

Patient Name: _____ **Date:** _____

6 Medical History

Name of Personal Physician: _____

Address/Clinic: _____ Phone #: _____

Date of Last Visit to Any Physician: _____

Reason for That Visit: _____

List any prescription or over-the-counter medications you are currently taking (including herbal supplements) and dosages:

_____

Are you allergic to any of the following? *Please check yes or no for each.*

YES	NO		YES	NO	
❑	❑	Aspirin	❑	❑	Dental Anesthetics
❑	❑	Codeine	❑	❑	Penicillin
❑	❑	Latex	❑	❑	Tetracycline
❑	❑	Sulfa	❑	❑	Erythromycin
❑	❑	Amoxicillin	❑	❑	Food Allergies

If you are aware of any adverse reactions to other medications, list them here: _____

Do you take antibiotic premedication for dental appointments?: _____

Have you ever had any of the following diseases or medical problems? *Please check yes or no for each item.*

YES	NO		YES	NO	
❑	❑	Arthritis	❑	❑	Joint/Bone Replacement
❑	❑	Asthma	❑	❑	Kidney Transplant
❑	❑	Blood Disease	❑	❑	Liver Disease
❑	❑	Breathing Problem	❑	❑	Low Blood Pressure
❑	❑	Cancer	❑	❑	Mental Health
❑	❑	Chemical Dependence	❑	❑	Mitral Valve Prolapse
❑	❑	Convulsions	❑	❑	Osteoporosis
❑	❑	Diabetes	❑	❑	Prolonged Bleeding
❑	❑	Dizziness	❑	❑	Radiation Treatment
❑	❑	Drug/Alcohol Abuse	❑	❑	Rheumatic Fever
❑	❑	Emphysema	❑	❑	Rheumatism
❑	❑	Frequent Headaches	❑	❑	Seizures
❑	❑	Heart Condition	❑	❑	Sinus Condition
❑	❑	Hepatitis	❑	❑	Sleeping/Snoring Problems
❑	❑	Herpes	❑	❑	Stroke
❑	❑	High Blood Pressure	❑	❑	TMJ
❑	❑	HIV	❑	❑	Tuberculosis
❑	❑	Immune Deficiency	❑	❑	Tumors/Growths
❑	❑	Jaundice			

Other medical notes: _____

Do you use tobacco in any form? ❑ Yes ❑ No If so, what form?
❑ Cigarettes ❑ Cigars ❑ Pipe ❑ Chewing Tobacco

Are you taking any medications for Osteoporosis? ❑ Yes ❑ No

FEMALES

Are you taking Birth Control Pills/Patch/Injections? ❑ Yes ❑ No
Are you pregnant? ❑ Yes ❑ No If yes, due date: _____
Are you nursing? ❑ Yes ❑ No

7 Dental History

What is the reason for today's visit: _____

_____

Are you currently in pain? ❑ Yes ❑ No

Have you ever had any serious/difficult problems with dental treatment? ❑ Yes ❑ No
If yes, please explain: _____

_____

Do your gums ever bleed? ❑ Yes ❑ No

Have you ever had:

Orthodontic Treatment (Braces)	❑ Yes	❑ No
Oral Surgery (Extractions)	❑ Yes	❑ No
Periodontal Treatment (Gum Disease)	❑ Yes	❑ No
A bite splint or mouth guard	❑ Yes	❑ No
A serious injury to the mouth or head	❑ Yes	❑ No

Have you experienced:

Clicking or popping of your jaw	❑ Yes	❑ No
Headaches, neck or shoulder pain	❑ Yes	❑ No

Please rate the current health of your teeth and gums:
❑ Excellent ❑ Average ❑ Poor

How many times a week do you floss? _____

How many times a day do you brush? _____

8 Dental Future

What would you change about your smile or bite, if you could?

_____

What is your biggest concern about having dental treatment?

_____

Some of our services include: *Please check any you'd like to hear more about.*

❑ Cosmetic Dentistry	❑ TMJ Splints
❑ Teeth Whitening	❑ Bad Breath Solutions
❑ Implants	❑ Metal-Free Restorations
❑ Lumineers, Veneers	❑ Invisalign Orthodontics

I understand the information I have given today is correct to the best of my knowledge. I also understand and accept my responsibility to inform this office of any changes in my medical status.

_____

Signature of Patient (or Guardian) Date

West Madison Dental
Stuart J. McCormick DDS