AVASON
FAMILY DENTISTRY

WELCOME

Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, please feel free to ask, we will be happy to help.

Patient Information:

(Please Print)

Name _____ Date _____
First MI Last

Preferred Name _____

Address _____ City _____ State/Zip _____

Birthdate _____ Home Phone# _____ Work # _____

SSN _____ Cell Phone# _____ DL# _____

Email Address: _____

If patient is a minor, give parent's or guardian's name _____

Occupation _____ Employer _____

Spouse Name _____ Spouse's Employer _____

Contact in case of emergency _____ Phone# _____

Whom may we thank for referring you? ❑ Patient _____ ❑ Newspaper ❑ Yellow Pages
❑ Welcome Committee ❑ Highway Signs ❑ Other _____

Insurance Information:

Who is responsible for this account _____

SSN _____ Birthdate _____ Relationship to patient _____

Employer _____ Work Phone# _____

Employer Address _____

Name of subscriber _____

Insurance Company _____ Group No. _____

Insurance Company Address _____

Is patient covered under additional dental insurance ❑ YES ❑ No

If yes, please give the additional insurance information on the lines provided: _____

Dental History:

(Please Print)

Previous Dentist _____ Date of last exam _____

Date of last x-rays _____

How often do you brush? _____ floss _____

Please check all that apply to you:

- ❒ Bad Breath
- ❒ Sensitivity to hot
- ❒ Bleeding gums
- ❒ Sensitivity when biting
- ❒ Swollen gums
- ❒ Sores or growth in mouth
- ❒ Grinding Teeth
- ❒ Sensitivity to sweets
- ❒ Loose teeth or broken fillings
- ❒ Food between teeth
- ❒ Sensitivity to cold
- ❒ Orthodontic treatment

Do you require an antibiotic before dental treatment? _____

Are you currently in pain? _____

Have you ever had a difficult problem associated with previous dental work? _____

Do you like your smile? _____ If no, what would you change _____

_____

Do you feel nervous about having dental treatment done? _____

Is there anything else about having dental treatment that you would like us to know? _____

_____

Medical History:

Physician _____ Date of last visit _____

Please list all medications you are currently taking _____

_____

Allergies _____

Women: Are you pregnant? ❒ YES ❒ No Nursing? ❒ YES ❒ No

Taking birth control pills? ❒ YES ❒ No

Do you have a history of the following?

- ❒ AIDS/HIV Positive
- ❒ Anemia
- ❒ Arthritis
- ❒ Artificial Heart Valves
- ❒ Asthma
- ❒ Back Problems
- ❒ Blood Disease
- ❒ Cancer
- ❒ Chemical Dependency
- ❒ Diabetes
- ❒ Epilepsy
- ❒ Glaucoma
- ❒ Headaches
- ❒ Heart Murmur
- ❒ Heart Problems
- ❒ Hemophilia
- ❒ Hepatitis
- ❒ Herpes/Fever Blisters
- ❒ High Blood Pressure
- ❒ Jaw Pain
- ❒ Kidney Disease
- ❒ Liver Disease
- ❒ Low Blood Pressure
- ❒ Mitral Valve Prolapse
- ❒ Pacemaker
- ❒ Psychiatric Care
- ❒ Radiation Treatment
- ❒ Respiratory Disease
- ❒ Rheumatic/Scarlet Fever
- ❒ Stroke
- ❒ Thyroid Problems
- ❒ Tobacco Use
- ❒ Tuberculosis
- ❒ Ulcers

Others not listed:

_____

_____

_____