Glendale Dental Assoc. II,PC
6202 Evanston Ave.
Indianapolis, IN 46220

(317)251-0085

Welcome to our Practice

Chart #. _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ SS #. _____ Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) _____ (Fax) _____ (Other)

Address: _____
_____ (City) _____ (State) _____ (Zip Code)

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Phone: _____

Address: _____
_____ (City) _____ (State) _____ (Zip Code)

Whom may we thank for referring you to our practice?

_____

In an emergency who should be notified? Please enter Name and Phone number below:

_____

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Parent/Guardian/Subscriber of Insurance

Please complete the following information if the patient is not the subscriber of the dental insurance or is a minor.

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ SS #. _____ Driver's License #: _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) _____ (Fax) _____ (Other)

Address: _____

_____ (City) _____ (State) _____ (Zip Code)

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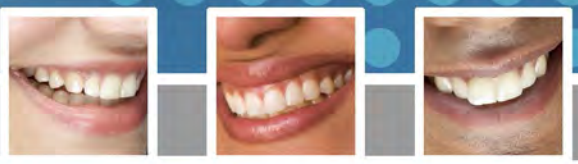

Primary Dental Insurance:

Name of Insured: _____ (Last) _____ (First) ____ (MI)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Subscriber ID and Insurance Group Number:

_____

Secondary Dental Insurance

Name of Insured: _____ (Last) _____ (First) ____ (MI)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Subscriber ID and Insurance Group Number:

_____

Insurance Authorization:

☐ By checking this box,
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

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Medical History

Indicate which of the following you have had or have at present. By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" response.

- ☐ *Pre-Med
- ☐ Allergic-Amoxicillin
- ☐ Allergies
- ☐ Allergy - Sulfa
- ☐ Allergy- Aspirin
- ☐ Allergy- Codeine
- ☐ Allergy- Latex
- ☐ Allergy- Penicillin
- ☐ Allergy- Tylenol
- ☐ Allergy-Tetracycline
- ☐ Allg.-Erythormycin
- ☐ Anemia
- ☐ Angina/chest Pain
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Artificil Hrt Valve
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer/Chem/Rad TX
- ☐ Cold Sores
- ☐ Coumadin
- ☐ Diabetes
- ☐ Drug/alcohol Addict
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Attack/Failure
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart/Brain Stent
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Irregular Heart Beat
- ☐ Jaundice
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mental Disorders
- ☐ Mitra Valve Prolapse
- ☐ Nervous Disorders
- ☐ Organ Transplant
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ See Note
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tatoos/Body Piercing
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease/STD

- ☐ Ever been hospitalized (illness or injury)
- ☐ Presently being treated for any other illnesses
- ☐ Taking medication for weight control (ie fen-phen)
- ☐ Taking dietary supplements
- ☐ Subject to frequent headaches
- ☐ A smoker or smoked previously
- ☐ FEMALE: Taking birth control pills
- ☐ FEMALE: Pregnant

If any conditions or alerts selected above needs further clarification, please describe below:

Do you take antibiotic premedication for your dental visits? If yes, please explain.

What is your estimate of your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Name of physician and their specialty:

Most recent physical exam and purpose:

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect you dental treatment.

List all medications, supplements, and/or vitamins taken within the last two years:

* ☐ By checking this box, I acknowledge that above information is correct and I understand it is my responsibility to inform the office of any changes in my health as soon as possible.

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Dental Information

How would you rate the condition of your mouth?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist name and how long have you been a patient there:

Date of most recent dental exam:

Date of most recent dental x-rays:

I routinely see my dentist every:

☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

What is your immediate concern?

Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most)

Personal History, Check all that apply:

☐ Had an unfavorable dental experience
☐ Had trouble getting numb
☐ Had/have braces, orthodontic treatment
☐ Had any teeth removed
☐ Had complications from past dental treatment
☐ Had any reactions to local anesthetic
☐ Had your bite adjusted

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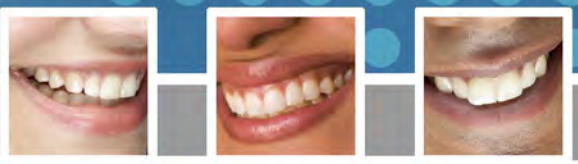

Smile Characteristics, Check all that apply:

- [ ] Is there anything about the appearance of your teeth that you would like to change?
- [ ] Have you ever whitened (bleached) your teeth?
- [ ] Have you felt uncomfortable or self conscious about the appearance of your teeth?
- [ ] Have you been disappointed with the appearance of previous dental work?

Bite and Jaw Joint, Check all that apply:

- [ ] You have problems with your jaw joint
- [ ] You have any problems chewing
- [ ] Your teeth changed in the last 5 years, become shorter, thinner, or worn
- [ ] Your teeth crowding or developing spaces
- [ ] You chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits
- [ ] You clench you teeth in the daytime or make them sore
- [ ] You have problems with sleep or wake up with an awareness of your teeth
- [ ] You wear or have worn a bite appliance

Tooth structure, Check all that apply:

- [ ] Cavities within past 3 years
- [ ] The amount of saliva in your mouth seems too little or you have difficulty swallowing any food
- [ ] You notice or have holes (i.e. pitting, crates) on the biting surface of your teeth
- [ ] Any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth
- [ ] Grooves or notches on your teeth, chipped teeth, or had a toothache or cracked filling
- [ ] Food gets caught between any teeth

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Gum and Bone, Check all that apply:

- [ ] Gums bleed when brushing or flossing
- [ ] Treated for gum disease or were told you have lost bone around your teeth
- [ ] Noticed an unpleasant taste or odor in your mouth
- [ ] History of periodontal disease in your family
- [ ] Experienced gum recession
- [ ] Had any teeth become loose on their own (without injury), or have difficulty eating an apple
- [ ] Experienced a burning sensation in your mouth

If any of the checked boxes need further explanation, please describe:

Response Date: