WELCOME TO SEAGO FAMILY DENTISTRY, PC seagodental.com

TODAY'S DATE: _____ **D.O.B.**_____ **SS#**_____

PATIENT'S NAME:_____
IF UNDER AGE 18, NAME OF PARENT OR GUARDIAN:_____

STREET ADDRESS:_____CITY:_____STATE:_____ZIP:_____

AT WHICH NUMBER DO YOU PREFER TO BE CONTACTED? (PLEASE CIRCLE)

CELL PHONE:_____ EMAIL:_____
HOME PHONE:_____ WORK PHONE:_____

DENTAL INSURANCE: YES OR NO

IF YES, EMPLOYER:_____ or, IS PLAN SELF-PURCHASED?_____
DENTAL INSURANCE CARRIER:_____ INSURANCE PHONE:_____
NAME OF POLICY SUBSCRIBER (employee):_____ RELATIONSHIP TO PATIENT:_____
SUBSCRIBER SS#:_____ SUBSCRIBER D.O.B.:_____
SUBSCRIBER ADDRESS (IF DIFFERENT):_____
STREET:_____CITY:_____STATE:_____ ZIP:_____
SUBSCRIBER PHONE (IF DIFFERENT):

PLEASE NOTE: PAYMENT AND/OR CO-PAY IS DUE AT TIME OF SERVICE. THANK YOU
We are proud to offer CareCredit Balance Financing. Ask at the desk or apply at carecredit.com!

DENTAL HISTORY (NEW PATIENTS ONLY)

DATE OF YOUR LAST DENTAL CLEANING:_____ X-RAYS:_____
DO YOU CURRENTLY HAVE ANY PAIN OR DISCOMFORT IN YOUR MOUTH?_____
IF YES, EXPLAIN:_____
HOW OFTEN DO YOU BRUSH/FLOSS YOUR TEETH?_____
HAVE YOU EVER HAD BRACES?_____ IF YES, AT WHAT AGE?_____
DO YOU HAVE AMALGAM (SILVER) FILLINGS IN YOUR MOUTH?_____
HAVE YOU EVER HAD SURGERY IN YOUR MOUTH?_____ IF YES, WHEN?_____
IF YOU HAVE HAD WISDOM TEETH REMOVED, WHEN?_____
HAVE YOU EVER HAD A BITE SPLINT?_____ IF YES, WHEN?_____
HAVE YOU EVER HAD PERIODONTAL TREATMENT?_____ IF YES, WHEN?_____
DO YOU EVER EXPERIENCE DRY MOUTH?_____
DO YOU HAVE ANY DENTAL IMPLANTS?_____ IF YES, HOW MANY?_____
HAVE YOU EVER HAD AN INJURY TO YOUR JAW OR MOUTH?_____ IF YES, WHEN?_____
DO YOU EVER HAVE CLICKING OR POPPING IN YOUR JAW?_____
DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?_____
ARE ANY OF YOUR TEETH SENSITIVE TO SWEETS, HOT OR COLD?_____
DO YOUR GUMS EVER FEEL SORE OR SWOLLEN?_____
DO YOU CLENCH OR GRIND YOUR TEETH?_____
DO ANY OF YOUR TEETH FEEL LOOSE OR MOVE?_____
IF YOU HAVE DENTURES, WHAT IS THE AGE OF THE APPLIANCE?_____
DO YOU LIKE THE APPEARANCE OF YOUR DENTURE?_____
IS YOUR DENTURE LOOSE, ILL-FITTING OR PAINFUL?_____
DO YOU LIKE THE APPEARANCE OF YOUR TEETH?_____
DO YOU LIKE THE APPEARANCE OF YOUR SMILE?_____
HAVE YOU EVER WHITENED YOUR TEETH?_____
DO YOU HAVE GAPS IN YOUR TEETH THAT BOTHER YOU?_____
DO YOU LIKE THE WAY YOUR TEETH FEEL?_____
IS THERE ANYTHING YOU'D LIKE TO IMPROVE OR CHANGE ABOUT YOUR TEETH OR SMILE?_____

(OVER)

HEALTH HISTORY

UPDATES (For Office Use) _____ _____ _____ _____ _____

PHYSICIAN'S NAME:_____ **PHONE:**_____
PHARMACY NAME:_____ **PHONE:**_____

ARE YOU UNDER A PHYSICIAN'S CARE NOW?_____ IF YES, PLEASE LIST REASON:_____
PLEASE LIST ALL SURGERIES YOU HAVE HAD IN THE PAST:_____
_____
DO YOU REQUIRE ANY SPECIAL ACCOMODATIONS FOR DENTAL TREATMENT?_____
IF YES, PLEASE EXPLAIN:_____
DO YOU HAVE OR EVER HAD HIGH BLOOD PRESSURE?_____
DO YOU USE ANY TYPE OF TOBACCO PRODUCTS?_____ IF YES, WHAT TYPE?_____
DO YOU USE ANY CONTROLLED SUBSTANCES?_____
DO YOU DRINK REGULAR OR DIET SODA?_____IF YES, HOW MUCH PER DAY?_____
DO YOU EVER GET COLD/CANKER SORES?_____
HAVE YOU EVER BEEN DIAGNOSED WITH A LATEX ALLERGY?_____
PLEASE CIRCLE ANY ALLERGIES: **PENICILLIN LATEX SULFA DRUGS CODEINE METALS ANESTHETICS**
OTHER:_____
WOMEN, ARE YOU PREGNANT OR TRYING TO BECOME PREGNANT?_____
DO YOU HAVE ANY OF THE FOLLOWING? **PACEMAKER STENT ARTIFICIAL VALVE ARTIFICIAL JOINTS IMPLANTS**
IF YES, WHEN?_____
ARE YOU CURRENTLY TAKING ANY BLOOD THINNING MEDICATION?_____ IF YES, PLEASE LIST:_____
HAVE YOU EVER HAD A HEART ATTACK/FAILURE?_____ IF YES, WHEN?_____

PLEASE CIRCLE ANY CONDITION YOU HAVE OR HAVE HAD IN THE PAST:

ALZHEIMER'S DISEASE
ANEMIA
ANGINA
ARTHRITIS
ASTHMA
BLOOD DISORDER
BREATHING PROBLEMS
CANCER
CHEMOTHERAPY/RADIATION
COLD SORES/HERPES
CONGENITAL HEART DISORDER
COPD/EMPHYSEMA
DIABETES
EPILEPSY OR SEIZURES
GLAUCOMA
HEART CONDITION OR DISEASE
HEART MURMUR
HEMOPHILIA
HEPATITIS A/B/C
HIIV/AIDS
JAUNDICE
KIDNEY PROBLEMS
LIVER PROBLEMS
LUPUS
MITRAL VALVE PROLAPSE
MULTIPLE SCLEROSIS
NECK/BACK PROBLEMS
NOSEBLEEDS
PSYCHIATRIC DISORDER
SICKLE CELL DISEASE
SINUS TROUBLE
STROKE
THYROID DISEASE
TONSILITIS
TUBERCULOSIS

PLEASE LIST ANY MEDICATIONS (PRESCRIPTION OR OVER-THE-COUNTER) YOU ARE CURRENTLY TAKING:

_____
_____
_____
_____
_____

ADDITIONAL COMMENTS:

_____
_____

PATIENT (OR GUARDIAN) SIGNATURE:_____ ***DATE:*** _____