WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. We strive to make every visit pleasant & Educational. Please fill out these forms completely. The better we communicate, the better we can care for you.

Gregory N. Bigelow, D.M.D Peter Pastrell, D.M.D. Justin D. Buchanan, D.D.S.

About You

Today's Date: _____

Name: _____
LAST FIRST MI MR. MRS. MS. DR.

I prefer to be called:_____ ❑ Male ❑ Female

Birthdate:_____/_____/_____ Age:_____ SS#_____

Mailing Address: _____
Appt # / Condo #

_____
CITY STATE ZIP

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Home Phone _____ Cell # _____

Work Phone _____ Ext. _____

E-mail address: _____

Employer: _____

Employer's Address: _____

How long there?_____ Occupation: _____

Where & when are best times to reach you? _____

Who may we Thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____
Please Circle

Last Visit Date: _____

Dental History

Why have you come to the dentist today? _____

_____

_____

Are you currently in pain? ❑ No ❑ Yes

Have you ever had a serious / difficult problem associated with any previous dental work? ❑ No ❑Yes

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ /TMD)? ❑ No ❑ Yes

Your current dental health is ❑ Good ❑ Fair ❑ Poor

Do you like your smile? ❑ No ❑ Yes Do your gums ever bleed? ❑ No ❑ Yes

How many times a week do you floss? _____ a day do you brush? _____

Type of bristles? ❑ Hard ❑ Medium ❑ Soft

Medical History

Do you have a personal physician? ❑ No ❑ Yes

Physician's Name:_____

Phone #: _____Date of last visit: _____

Your current physical health is ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician ❑ No ❑ Yes

Please explain _____

Are you taking any prescription/over the counter drugs? ❑ No ❑ Yes

Please list each one _____

_____

For Women Are you taking birth control pills? ❑ No ❑ Yes

Are you pregnant? ❑ No ❑ Yes Week # _____

Are you nursing? ❑ No ❑ Yes

Do you smoke? ❑ No ❑ Yes

Have you ever had any of the following diseases or medical problems?

Y N	Heart Attack / Stroke	Y N	Psychiatric Problems
Y N	Cancer / Chemotherapy	Y N	Epilepsy / Seizures / Fainting Spells
Y N	Heart Murmur	Y N	Diabetes / Tuberculosis (TB)
Y N	Rheumatic Fever	Y N	Drug / Alcohol Abuse
Y N	HIV+ / AIDS	Y N	Venereal Disease
Y N	Heart Surgery / Pacemaker	Y N	Hemophilia / Abnormal Bleeding
Y N	Shingles	Y N	Ulcers / Colitis
Y N	Mitral Valve Prolapse	Y N	Anemia / Radiation Treatment
Y N	Kidney Problems	Y N	Asthma / Arthritis
Y N	Artificial Bones / Joints	Y N	Hospitalized for Any Reason
Y N	Sinus Problems	Y N	Hepatitis
Y N	High / Low Blood Pressure	Y N	Blood Transfusion
Y N	Fever Blisters	Y N	Emphysema / Glaucoma
Y N	Severe / Frequent Headaches	Y N	Thyroid
Y N	Artificial Valves	Y N	Congenital Heart Defect
Y N	Difficulty Breathing		

Please list any serious medical condition(s) that you have ever had:

_____

_____

_____

Do You smoke? ❑ No ❑ Yes

Are you allergic to any of the following drugs?

Y N	Penicillin	Y N	Tetracycline	Y N	Latex
Y N	Aspirin	Y N	Dental Anesthetics	Y N	Other
Y N	Erythromycin	Y N	Codeine		

Please list any other drugs that you are allergic to:

_____

_____

Please fill out both sides of this form

Spouse Information

Spouse's Name: _____

Employer: _____

Wk # : _____Ext _____SS# _____

Birthdate:_____ DL# _____

Person Responsible for Account: _____

Wk # : _____Ext _____

Home # _____

Employer:_____ DL# _____

Child Information

Who is accompanying the child today?

Name: _____ Relation: _____

Do you have legal custody of this child? ❑ No ❑ Yes

Who is responsible for making appointments?

Name: _____

Wk #: _____ Ext. _____ Hm #: _____

Is the child's water fluoridated? ❑ No ❑ Yes

Is the Child taking fluoridated supplements? ❑ No ❑ Yes

Does the child have any of the following habits?

Y N Thumb / Finger Sucking

Y N Lip Sucking / Biting

Y N Nail Biting

Y N Nursing Bottle Habits

For Office Use Only

Medical History Update

1. Date: _____ Signature: _____

   Comments: _____

   _____

2. Date: _____ Signature: _____

   Comments:_____

   _____

Dental Insurance

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone # _____

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

Insured's Name: _____ Relation: _____

Insured's Birthday: ____/____/____ Insured's SS# _____

Insured's Employer: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone # _____

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

Insured's Name: _____ Relation: _____

Insured's Birthday: ____/____/____ Insured's SS#: _____

Insured's Employer: _____

In the event of an emergency, is there someone who lives near you that we should contact?

Their Name: _____Relation:_____

Work #: _____

Home #: _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

_____

Signature Date

Payment is due in full at the time of treatment unless prior arrangements have been approved.

We thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help.

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Please fill out both sides of this form

Bigelow, Pastrell, & Buchanan Family Dentistry, LLC.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____