



## Welcome to Integrative Family Dentistry Medical/Dental History

### **Patient Information**

Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: M \_\_\_\_\_ F \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

### **Parent/Guardian Information**

Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: M \_\_\_\_\_ F \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

### **Insurance**

Name of Insured: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Employer: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Group Number: \_\_\_\_\_ Phone Number: \_\_\_\_\_

***If you have additional dental insurance please notify our staff.***

How did you select Integrative Family Dentistry?

\_\_\_\_\_ Referral; Name: \_\_\_\_\_

\_\_\_\_\_ Office Appearance

\_\_\_\_\_ Website

\_\_\_\_\_ Dental Insurance

\_\_\_\_\_ Dentist Referral

\_\_\_\_\_ Newspaper Ad

\_\_\_\_\_ Other: \_\_\_\_\_



Are you using any recreational drugs (i.e. marijuana, cocaine, or meth)?  Yes  No

Would you consent to a blood test (at our expense) in case of a needlestick?  Yes  No

**Dental History**

When was the last time you visited the dentist? When \_\_\_\_\_ Where \_\_\_\_\_

When was the last time you got your teeth cleaned? When \_\_\_\_\_ Where \_\_\_\_\_

Do you usually see a dentist every six months?  Yes  No

Have you ever had to take antibiotics before dental treatment?  Yes  No

May we take dental x-rays if they are needed?  Yes  No

Do you have fluoride in your drinking water?  Yes  No

Do you take a fluoride supplement?  Yes  No

Do floss regularly?  Yes  No

What kind of toothbrush do you use?  Hard  Medium  Soft

I have read and understand the above questions. I have answered all of the questions truthfully and to the best of my ability and knowledge.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
Patient or Guardian

Relationship \_\_\_\_\_