Welcome!

Thank you for selecting Cole Family Dentistry! We will strive to provide you with the best possible dental care. To help us meet your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us, and we would be happy to help!

Patient Information

Patient # _______________ (office use only)
Name ____
Birth date ___________________ Social Security # ____________________
Address ____
City ___________________________ State ________ Zip __________
Home Phone _________________ Work __________________Cell _________________
Email _______________________________ Would you like to receive confirmation notices via email or text? (Please specify which) _________________________________

Please check one that applies: Minor__ Single__ Married__ Divorced __ Widowed__
If Minor, Name of Guardian/Parent ____
If Student, Name of School/College ____

Whom may we thank for referring you? _______________________________________

Person to Contact in case of Emergency _______________________ Phone __________

Insurance Information

If you were provided with a card from your insurance company, please present it to our front desk.

Name of Insured ____
Birth date ___________________ Social Security # ______________________
Relationship to Patient _______________________________
Name of Employer _________________________________ Work Phone ____________
Insurance Company ____
Group # _______________________________ ID # ______________________________
Insurance Company Address ____
City __________________________ State ______Zip _________Effective Date _______

Additional Insurance Coverage? Please list below.

Name of Insured ____
Birth date ___________________ Social Security # ______________________
Relationship to Patient _______________________________
Name of Employer _________________________________ Work Phone ____________
Insurance Company ____
Group # _______________________________ ID # ______________________________
Insurance Company Address ____
City __________________________ State ______Zip _________Effective Date _______

Patient Medical History

Physician ______________________ Phone _________________ Date of Last Exam ______

Are you under any medical treatment now? (Please Circle) NO YES

If yes, please explain ____

Have you had any hospitalizations/surgeries within the last 5 years? NO YES

If yes, please explain____

Are you currently taking any medications? NO YES

If yes, please list (include any vitamins/herbal supplements ___________________________________

____

Do you use tobacco products? NO YES

Are you allergic to or have you had any reactions to the following? (Please check all that apply)

__Local Anesthetics (Novocain)
__Penicillin or any other Antibiotics
__ Sulfa Drugs
__Latex Rubber
__Aspirin
__Other: ________________

Do you have or have you had any of the following? (Please check all that apply)

__High Blood Pressure
__Heart Attack
__Heart Disease
__Rheumatic Fever
__Fainting/Seizures
__Asthma
__Low Blood Pressure
__Epilepsy/Convulsions
__ Leukemia
__Diabetes
__Kidney Disease
__AIDS or HIV infection
__Thyroid Problem
__Cardiac Pacemaker
__Heart Murmur
__Angina
__Anemia
__Emphysema
__Cancer
__Arthritis
__Joint Replacement
__Hepatitis (specify type)
__Chest Pains
__Stroke
__Hay Fever/Allergies
__Tuberculosis
__Radiation Therapy
__Glaucoma
__Liver Disease
__Respiratory Problems
__Mitral Valve Prolapse
__Other: __________
____

Previous Dentist ____ Last Exam ______________

Do your gums bleed while brushing or flossing? NO YES

Do you feel any pain to any of your teeth? NO YES __________________________

Do you grind/clench your teeth? NO YES

Have you had any orthodontic treatment? NO YES

Do you like your smile? ____

____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information medical/dental information to other health practitioners if it is beneficial or crucial to my health.

X____ __________________________

Signature of patient (or parent/guardian if minor) Date