HELENA FAMILY DENTISTRY
John E. Smith, DMD | Michael J. Welch, DDS

Welcome to our Practice

Patient Name: ______________________________ _____ Preferred Name: ___________
First Last MI

Gender: ☐ Male ☐ Female Family Status: ☐ Married ☐ Single ☐ Child ☐ Other

Date of Birth: __________________ SSN: _________________________

Phone: _________________ __________________ _____________ _____ _____________
Cell Home Work Ext Other

Address: ____________________________________ ________________________________
Address 1 Address 2

____________________________________ __________ ______________
City State Zip Code

Email Address: ____

Who may we thank for referring you to our office? __________________________________

In an emergency who should be notified?

Name ________________________ Relation: ___________ Phone Number ______________

Employment Information

The following is for: ☐ **The patient** ☐**The person responsible for payment** ☐**Both** ☐ **Neither**

Employer Name: _____________________________________ Phone: __________________

Employer Address: ____

_____________________________ _____________________ __________________
City **State** **Zip Code**

Responsible Party Information

*This only needs to be completed if the insurance subscriber is someone other than the patient, or you are the parent/guardian of the patient.

The following is for: □ the patient's spouse □ the person responsible for payment □both □ N/A

Name: ____________________ ____________________ __________ ________________
Last First MI Preferred Name

Gender: □ Male □ Female **Family Status:** □ Married □ Single □ Child □ Other

Date of Birth: __________________ **SSN:** _________________________

Phone: _________________ __________________ _____________ _____ _____________
Cell Home Work Ext Other

Address: ____________________________________ ________________________________
Address 1 Address 2

____________________________________ __________ ______________
City State Zip Code

Email Address: ____

Primary Dental Insurance

Insurance Plan Name: ____

ID# ___________________________________ **Group #:** ____________________________

Insurance Address: ____________________________ _______________________________
Address 1 Address 2

_______________________________________ ___________ _________________________
City State Zip Code

Insurance Company Phone Number: ____

Insured's Employer Name: ____

*If you have a secondary dental insurance, please provide this information to the front desk.

Dental Information and History

What is your immediate concern? ____

Previous Dentist Name and Phone Number:

____

Date of most recent dental exam and dental x-rays? _________________________________

Is there anything about the appearance of your smile that you would like to change?

____

Check all that apply:

☐ Had complications from past dental treatment
☐ Had trouble getting numb
☐ Had any reactions to local anesthetic
☐ Had/have braces, orthodontic treatment
☐ You experience dry mouth
☐ Any teeth sensitive to hot, cold, biting, sweets or avoid brushing any part of your mouth
☐ Food gets trapped between any teeth
☐ Have you ever whitened or bleached your teeth
☐ Have you experienced popping and/or clicking of your jaw joint
☐ You have difficulty chewing
☐ You clench or grind your teeth
☐ You wear or have worn a bite appliance
☐ 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
☐ Experienced gum recession
☐ Had any teeth become loose on their own (without injury)
☐ Experienced a burning sensation in your mouth
☐ You snore or wake up frequently during the night

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

____
____
____

Medical History

Indicate which of the following conditions you have or have had. By checking the box it will indicate "YES" response, leaving blank will indicate "NO" response.

☐ Alcohol Sensitivity	☐ Alcoholism	☐Allergy- Latex	☐ Allergy- Other
☐ Allergy- Penicillin	☐ Anemia	☐ Arthritis	☐ Artif. Heart Valve
☐ Artificial Joints	☐ Asthma	☐ Bisphosphonates	☐ Blood Thinners
☐ Breathing Problems	☐ Bruise Easily	☐ Cancer	☐ Chemotherapy
☐ Chest Pains	☐ Cold Sores	☐ Congen, Heart Defect	☐ Corticosteroids
☐ Crohn's Disease	☐ Diabetes	☐ Eating Disorder	☐ Epilepsy/Seizures
☐ Excessive Bleeding	☐ Fainting/Dizziness	☐ Frequent Headaches	☐ Gastric Reflux
☐ Glaucoma	☐ HIV	☐ HPV	☐ Head Injury
☐ Heart Attack	☐ Heart Problems	☐ Heart Valve Problems	☐ Hemophilia
☐ Hepatitis	☐ High Blood Pressure	☐ Kidney Problems	☐ Liver Problems
☐ Neurodegen. Disease	☐ Osteoporosis	☐ Other	☐ Pacemaker
☐ Psychiatric Care	☐ Radiation Treatment	☐ Sinus Problems	☐ Sleep Apnea
☐ Snoring	☐ Stomach Problems	☐ Stroke	☐ Substance/Drug Use
☐ Thyroid Condition	☐ Tobacco Use	☐ Tuberculosis	☐ Ulcers

Please explain/Clarify any conditions or alerts selected above:

____

____

Allergies not listed: ____

Do you take antibiotic premedication for you dental visits? ☐ Yes ☐No
If yes, Please explain: ___________________________________Pre-Med: _____________

Do you use any smoke or smokeless products? (E-cigarettes, ZYN pouches, etc.) ☐ Yes ☐ No
If yes, what Products? ____

Name of your Physician? _____________________ Preferred Pharmacy: ________________

Women: If you are pregnant at this time, when is your due date? ________________________

Current Medications: (If you have a copy or written form we can always scan into your chart)

____

____

Signature: ____
By signing, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed.