

WELCOME

DAVID A. NORSTEDT, D.M.D.

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

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About You

Today's Date: _____

Name: _____

I prefer to be called: _____ Male Female

Birthdate: / / Age: SS#: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Single Married Divorced Widowed Separated

Home #: _____ Pager/Other #: _____

WK#: _____ Ext: _____ DL#: _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

When & where are the best times to reach you? _____

Whom may we Thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____

Last Visit Date: _____

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Dental Insurance

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Tel #: _____

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. Tel #: _____

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

Insured's Name: _____ Relation: _____

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

Insured's Employer: _____

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Other Information

Spouse / Parent Name: _____

Employer: _____

WK#: _____ Ext: _____ SS#: _____

Birthdate: / / Age: _____ DL#: _____

Person Responsible for Account: _____

WK#: _____ Ext: _____ HM#: _____

Billing Address: _____

Relationship: _____ SS#: _____

Employer: _____ DL#: _____

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Medical History

Do you have a personal physician? No Yes

Physician's Name: _____

Phone #: _____ Last Visit Date: _____

For emergencies, please give us the name and number of someone not living in your household.

Their Name: _____ Relation: _____

WK#: _____ HM#: _____

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Medical History continued

Your current physical health is Good Fair Poor

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

Please Explain: _____

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

Please list each one: _____

For Women Are you taking birth control pills? Yes No

Are you pregnant? Yes No Week # _____

Are you nursing? Yes No

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

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

Please list other medical condition(s) that you have ever had: _____

Are you allergic to any of the following drugs?

- | | | |
|--|--|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Penicillin | <input type="checkbox"/> Y <input type="checkbox"/> N Tetracycline | <input type="checkbox"/> Y <input type="checkbox"/> N Latex |
| <input type="checkbox"/> Y <input type="checkbox"/> N Aspirin | <input type="checkbox"/> Y <input type="checkbox"/> N Dental Anesthetics | <input type="checkbox"/> Y <input type="checkbox"/> N Other |
| <input type="checkbox"/> Y <input type="checkbox"/> N Erythromycin | <input type="checkbox"/> Y <input type="checkbox"/> N Codeine | |

Please list any other drugs that you are allergic to: _____

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Dental History

Why have you come to the dentist today? _____

Do you prefer Nitrous Gas? Yes No

Are you currently in pain? Yes No

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

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

Your current dental health is Good Fair Poor

Do you like your smile? Yes No

Do your gums ever bleed? Yes No

How many times a week do you floss? _____

How many times a day do you brush? _____



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 of 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 time of treatment unless prior arrangements have been approved.



! 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.

I verbally reviewed the medical / dental information above with the patient named herein. Initials _____ Date _____

Doctor's comments _____

MEDICAL HISTORY UPDATE

- | | | |
|---------------|----------------|-----------------|
| 1. Date _____ | Comments _____ | Signature _____ |
| 2. Date _____ | Comments _____ | Signature _____ |
| 3. Date _____ | Comments _____ | Signature _____ |