OVERMEYER
FAMILY DENTAL

Personal Information

Single Widowed

Name: _____ Divorced Married, Spouse's name: _____

Address: _____ Apt #_____ City/State/Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Age: _____ Date of Birth: _____ Social Security Number: _____

Drivers License Number: _____ Employer: _____

E-Mail Address: _____

By What Means were you referred to our office: Google Friend or Family Member

Mailer Other: _____

Name of person who referred you: _____

Person Responsible for this Account: _____

Dental Insurance Information

Primary Insurance:

Ins. Co: _____

ID #: _____

Group Name: _____

Group Number: _____

Telephone: _____

Insured Name: _____

Insured DOB: _____

Insured SSN: _____

Secondary Insurance:

Ins. Co: _____

ID #: _____

Group Name: _____

Group Number: _____

Telephone: _____

Insured Name: _____

Insured DOB: _____

Insured SSN: _____

General Health Information:

Do you have or have you ever had any of the following? (circle all that apply)

Artificial Hip, Knee, Joint
Date of replacement:_____
Pre-Med Needed? Y/N
Heart Murmur
Mitral Valve Prolapse
Jaundice
Hepatitis/ Liver Disorder
Type:_____
Epilepsy or Seizures
High Blood Pressure
Diabetes
Type:_____

Stroke
Kidney Trouble
Heart Trouble
Heart Attack
Date:_____
Venerial Disease
H.I.V Positive
A.I.D.S
Tuberculosis
Cancer
Radiation Therapy
Chemo Therapy

Mental Illness
Asthma
Hay Fever
Extreme Weight Loss/Gain
Glaucoma
Bruise Easily
Anemia
Neck or Head Pain
Migraines
per week:_____
Currently Pregnant? Y/N
months_____

2. Are you under the care of a physician now: CIRCLE ONE Yes No
If Yes, Why?_____

3. Have any medications made you ill or caused an allergic reaction CIRCLE ONE Yes No
List these Medications_____

4. List Previous Surgeries_____

5. List Drugs and Medications you currently take:_____

6. Have you ever had any clotting or bleeding problems? CIRCLE ONE Yes No
Explain:_____

7. Current Physicians:
G.P. or Primary Care_____
Specialists_____

DENTAL HEALTH QUESTIONAIRE

1.Do you have fear of going to the dentist? Yes No
2.Do you floss daily? Yes No
3.Do you smoke? Yes No
4.Are your teeth sensitive to.....(Circle) Hot Cold Sweets
5.Does food catch between your teeth? Yes No
6.Do your gums bleed when brushing? Yes No
7.Have you noticed any gum swelling around your teeth? Yes No
8.Are any teeth loose? Yes No
9.Do you have bad breath? Yes No
10.Are you satisfied with the appearance and color of your teeth? Yes No
11.When was your last dental exam?_____
12.Why did you leave your last dentist?_____
13.Do any teeth hurt? If so, which ones ?_____
14.What is your immediate concern or reason for todays visit?_____
15. Do You snore?_____

AUTHORIZATION AND RELEASE

I understand that the information that I have given today is correct to the best of my knowledge. I also understand tha this information will be held in the strictest of confidence and it is my responsibility to inform this office of any change in my medical status. I authorize the dental staff to preform the necessary dental services for my treatment and/or diagnosis.

Signature_____Date_____