Welcome

Britt D. Vinson, D.D.S., M.S.D

Date: ______________________ E-Mail: ______________________

Mr. ____Mrs. _____Ms. ____Miss ____Dr. ____ Sex: ______________

Patient Name: ______________________ SSN: ______________________

Birthday: ______________________ Work Phone: ______________________

Home Phone: ______________________ Place of Work: ______________________

Address: ______________________ Spouse's Name:______________________

______________________ Spouse's work: ______________________

Dentist: ______________________ Referred by: ______________________

Insurance Information

Insurance Company: ______________________Group # ______________

Address: ______________________

Phone #: ______________________ SSN: ______________________

Employer Name: ______________________

Additional Information

Reason for Appointment: ______________________

List family members that have been treated by this practice: ______________________

Have you had previous orthodontic treatment? _______Yes ________No , When? ______________

Have you had problems with previous dental treatment? ______________________

Have you been treated by a periodontist? ______________________

Have you ever had a fractured jaw? ______________________

Have you been treated for TMJ? ______________________

Do you need to be pre-medicated before dental treatment? ______________________

(over)

Medical History

Patient Name: ________________________________ Birth Date: ________________________________

Are you in good health? _______________If not explain ____

Do you have any allergies to medicines (drugs) or medical products (latex)? ___________________________

Have you ever been treated by a physician for :

(Circle all that apply)

Heart Murmur	Heart Disease	Rheumatic Fever	Anemia	Sickle Cell Anemia
Sickle Cell Anemia	Bleeding/Hemophilia	Hepatitis	AIDS/HIV	Tuberculosis
Diabetes	Arthritis	Cancer	Seizures	Asthma
Cleft lip/Palate	Speech/Hearing Problems		Tonsils/Adenoids/ Sinus Problems	
Sleep Problems	Emotional/Behavior Problems			

Explain any circled item(s): ____

List daily medications you are presently taking: ____

Dental History

Dentist: __________________________________ Date of last visit: _____________________________

(Circle all that apply)

Have had complications following dental treatment	Currently have cavities/toothaches that need treatment
Has Clicking/ Popping or Jaw pain	Grind or clench teeth day or night
Ever injured any teeth	Ever injured jaws or face
Needs to be pre-medicated before dental treatment	Have had tonsils/adenoids removed

Explain any circled item(s): ____

Realizing that successful treatment greatly depends upon your cooperation in following instructions, keeping appointments and maintaining oral hygiene. Are there any restriction, handicaps, or problems that might be encountered during treatment? _______Yes ________No, if yes please explain: _________________________

____

Signature: ____