

# Welcome

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

Date: \_\_\_\_\_

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: \_\_\_\_\_

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## 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 :

(Choose 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: \_\_\_\_\_

(Choose 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: \_\_\_\_\_

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Signature: \_\_\_\_\_