WELCOME

To Our Office!
Tammy R. Severt, D.D.S., P.A.
www.severtsmiles.com

Please complete this form on both sides.

Date:______________________________

About You:

Name: ______________________________________
Dr Mr Mrs Ms First MI Last
I prefer to be called:______________________________
☐ Male ☐ Female Date of Birth:__________________
SS#: _______________________________________
Home Address:______________________________
Street Apt/Condo #
____
City State Zip
Home Telephone: (____)________________________
Mobile Telephone:(____)________________________
Work Telephone:____________________ext.:________
E-mail:______________________________________
Employer: ___________________________________
Position/Occupation:_____________________________
Where and when are the best times to contact you?
____
☐Single ☐Married ☐Divorced ☐ Widowed ☐Separated
Spouse's Name: _______________________________
Spouse's Work #:_______________________________
General Dentist:________________________________
Date of Dental Exam:____________________________
Other family members seen in our office:____________
____
Whom may we thank for referring you?_____________
____

Person Responsible for Account:

☐ Same as Above (patient is responsible party)
If other than patient:
Name:______________________________________
Relationship to Patient: _________________________
Billing Address: _______________________________
Street Apt/Condo #
____
City State Zip
Home Telephone:(____)__________________________
Work Telephone: (____)________________ext.:______

Medical History:

Physician's Name:____________________
Date of Last Visit: ____________________
Your Current Health is: ☐Good ☐Fair ☐Poor
Are you currently under the care of a physician?
☐Yes ☐No
Explain if yes:______________________________
Are you currently taking any medications?
(include over the counter) ☐Yes ☐No
Please list each drug:_______________________
____
For Women: Are you (possibly) pregnant?
☐Yes ☐No
Are you currently nursing?
☐Yes ☐No

Do you have or have you ever had any of the following diseases or medical conditions?
(please circle)

Abnormal Bleeding	Herpes
Acquired Immune Disorders	Hepatitis
Anemia	High Blood Pressure
Artificial Joints/Valves	Hospitalization
Arthritis	Kidney Problems
Asthma	Low Blood Pressure
Blood Transfusion	Lung Problems
Cancer	Migraines
Congenital Heart Defect	Mitral Valve Prolapse
Diabetes	Psychiatric Problems
Difficulty Breathing	Radiation Treatment
Drug/Alcohol Abuse	Rheumatic Fever
Emphysema	Seasonal Allergies
Epilepsy/Seizures	Shingles
Glaucoma	Sinus Problems
Headaches	Surgery
Heart Attack	Tuberculosis
Heart Murmur	Ulcers/Colitis
Heart Surgery/Pacemaker	Vision/Hearing
Hemophilia	Other

Please explain any circled responses:__________
____

Are you allergic to any of the following? (please circle)

Anesthetics	Aspirin/Ibuprofen	Codeine	Cyclosporins	Erythromycin	Latex
Metal	Penicillin	Sulfa Drugs	Tetracycline	Other	

Please list any other drugs or materials that you may be allergic to:
____

Dental History

What are your main concerns regarding the health or appearance of your teeth?_______________________________________
____
____
What do you hope orthodontic treatment will accomplish?____
____

Have you ever been told that you require antibiotics before dental treatment?...................... ☐Yes ☐ No
Have you ever had an injury to your face, mouth or teeth?.. ☐Yes ☐ No

If yes, please explain:____

Have you ever had joint (TMJ) pain or discomfort?.. ☐Yes ☐ No

If yes, please explain:____

Do you see your dentist regularly (every six months)?.. ☐Yes ☐ No

Your current dental health is:…………………………………………………………………............. ☐Good ☐Fair ☐Poor

Do your gums bleed frequently?.. ☐Yes ☐ No

Do you have any missing or extra permanent teeth?... ☐Yes ☐ No

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

If yes, please explain:____
Have you ever had orthodontic treatment?... ☐Yes ☐ No

If yes, when and where?____

In the event of an emergency, is there someone who lives near you that we can contact?

Name:__________________________________ Relationship to patient:____________________________

Work Telephone:__________________________ Home Telephone:________________________________

The information I have provided on this form is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office on any changes in my medical status. I authorize the doctors and staff to perform any necessary dental procedures during diagnosis and treatment with my informed consent.

____ ____________________________________

Signature Date

The office reserves the right to verify the credit status of potential patients prior to determining a payment plan for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting agencies.

____ ____________________________________

Signature Date

For Office Use Only