ARTHUR GLOSMAN, DDS
AESTHETIC AND RESTORATIVE DENTISTRY

WELCOME!

ABOUT YOU

Today's Date: _____ E-mail Address: _____

Name: _____ I prefer to be called: _____ ☐ Male ☐ Female
Last First Mi Mr Mrs Ms Dr

Birthday: ____/____/____ Age: _____ Social Security #: _____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home Address: _____
Street City State Zip

Home Phone #: (____) _____ Cell/other #: (____) _____ Work Phone #: (____) _____ Ext: _____ Driver's License #: _____

Where & when are best times to reach you? _____ Whom may we thank for referring you? _____

Other family members seen by us: _____

Employer: _____ How long there: _____ Occupation: _____

Employer's Address: _____
Street / P.O. Box City State Zip

NEIGHBOR OR RELATIVE NOT LIVING WITH YOU

His/Her Name: _____ Relation: _____ Work Phone #: (____) _____ Home Phone #: (____) _____

Address: _____
Street City State Zip

SPOUSE INFORMATION

His/Her Name: _____ Birthday: ____/____/____ Social Security #: _____

Employer: _____ Work Phone #: (____) _____ Ext: _____ Driver's License #: _____

INSURANCE INFORMATION

Primary Insurance Dental Coverage? ☐ Yes ☐ No Orthodontic Coverage? ☐ Yes ☐ No Medical Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____ Phone #: (____) _____ Group #: (Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street / P.O. Box City State Zip

Insured's Name: _____ Insured's Social Security #: _____ Insured's Birthdate: ____/____/____ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street / P.O. Box City State Zip

Second Insurance Dental Coverage? ☐ Yes ☐ No Orthodontic Coverage? ☐ Yes ☐ No Medical Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____ Phone #: (____) _____ Group #: (Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street / P.O. Box City State Zip

Insured's Name: _____ Insured's Social Security #: _____ Insured's Birthdate: ____/____/____ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street / P.O. Box City State Zip

CONTINUED ON BACK

DENTAL HISTORY

Why have you come to the dentist today? _____

_____

Are you currently in pain? ☐Yes ☐No

Do you require antibiotics before dental treatment? ☐Yes ☐No

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

Do you floss daily? ☐Yes ☐No Brush daily? ☐Yes ☐No

Type of bristles on your toothbrush? ☐Hard ☐Medium ☐Soft

Do your gums ever bleed? ☐Yes ☐No

Have you ever had periodontal disease? ☐Yes ☐No

Are your teeth sensitive to heat, cold, or anything else? _____

Do you have mobility in your teeth? ☐Yes ☐No

Do you still have wisdom teeth? ☐Yes ☐No

Previous / Present Dentist: _____ Last Visit Date: _____
(Please Circle)

Would you like fresher breath? ☐Yes ☐No Whiter teeth? ☐Yes ☐No

Are you happy with the way your smile looks? ☐Yes ☐No

If not, what would you change? _____

_____

MEDICAL HISTORY

Do you have a personal physician? ☐Yes ☐No

Physician's Name: _____

Address: _____
Street

_____
City State Zip

Phone #: (____) _____ Date of last visit: _____

Your current physical health is: ☐Good ☐Fair ☐Poor

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

Please explain: _____

Do you smoke or use tobacco in any other form? ☐Yes ☐No

Have you ever taken Phen-Fen, Redux or Pondimin? ☐Yes ☐No

For Women: Are you taking birth control pills? ☐Yes ☐No

Are you pregnant? ☐ Unsure ☐Yes ☐No

Week #: _____ Are you nursing? ☐Yes ☐No

DO YOU OR HAVE YOU EXPERIENCED THE FOLLOWING?

Y N Abnormal Bleeding	Y N Colitis	Y N Hay Fever	Y N Liver Disease	Y N Shingles
Y N Alcohol Abuse	Y N Congenital Heart Defect	Y N Headaches	Y N Low Blood Pressure	Y N Sickle Cell Disease
Y N Anemia	Y N Diabetes	Y N Heart Attack	Y N Lupus	Y N Sinus Problems
Y N Arthritis	Y N Difficulty Breathing	Y N Heart Murmur	Y N Mitral Valve Prolapse	Y N Steroid Therapy
Y N Artificial Bones/Joints	Y N Drug Abuse	Y N Heart Surgery	Y N Pacemaker	Y N Stroke
Y N Artificial Valves	Y N Emphysema	Y N Hemophilia	Y N Persistent Cough	Y N Thyroid Problems
Y N Asthma	Y N Epilepsy	Y N Hepatitis	Y N Psychiatric Problems	Y N Tonsillitis
Y N Blood Transfusion	Y N Ever Hospitalized	Y N Herpes	Y N Radiation Treatment	Y N Tuberculosis
Y N Cancer	Y N Fainting Spells	Y N High Blood Pressure	Y N Rheumatic Fever	Y N Ulcers
Y N Chemotherapy	Y N Fever Blisters	Y N HIV+ / AIDS	Y N Scarlet Fever	Y N Venereal Disease
Y N Chicken Pox	Y N Glaucoma	Y N Kidney Problems	Y N Seizures	

Please list any serious medical condition(s) that you have experienced: _____

Are you taking any prescription/over the counter drugs? ☐Yes ☐No If yes, please list each one: _____

_____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Y N Aspirin	Y N Codeine	Y N Erythromycin	Y N Latex	Y N Sedatives	Y N Tetracycline
Y N Barbiturates	Y N Dental Anesthetics	Y N Jewelry / Metals	Y N Penicillin	Y N Sulfa Drugs	Y N Other

Please list anything additional that causes allergic reactions: _____

_____

AUTHORIZATION

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary service I may need. I assign the Doctor all insurance benefits. I understand that I am responsible for payment of service rendered, any deductible, and co-payment that my insurance does not cover. I have received a copy of this office's Notice of Policy Practice.

Signature: _____ Date: _____

CONSENT FOR TREATMENT

I hereby authorize the above named doctor and/or his auxiliaries to perform all necessary dental treatment indicated in my record and to do whatever other procedures are deemed advisable in their judgement. I also authorize the administration of such medication and/or anesthetics as may be recommended. It has been explained to me, and I understand that results of treatment and services are not guaranteed or warranted and cannot be so.

I have read and understand the above: _____
(Signature of patient or guardian and date)