Welcome to the office of Timothy Ference D.D.S.

How did you hear about our office?
(Please check all that apply)

- ☐ Friend/Family: _____
- ☐ Internet Search
- ☐ Our website
- ☐ Insurance Company:_____
- ☐ Other_____

Personal/ Health History of:

Name:_____
Date:_____

Personal Information:

Marital status (please circle one) Married Single

Birthdate:_____

Social Security #:_____

Home Address:
_____

City:_____State:_____Zip:_____

Email address:_____

Home Phone:_____

Cell Phone:_____

Work
Phone:_____

Emergency Contact: _____
Phone:_____

Employment Information:

Employer:_____
Do you have dental insurance (please check one)?

- ☐ Yes
- ☐ No

If yes, how is it provided?

- ☐ Through my employer
- ☐ Through my spouse's employer
- ☐ Through my family member _____
- ☐ Through a private provider

Insurance Information:
PLEASE provide your insurance card to receptionist for scanning at each visit:
Insurance Company Name:_____

Group/Employer Name:_____

Member ID/Social SS#:_____

Group Number:_____

Insurance Company Address:
_____

Phone #_____Payor ID:_____

Personal Information of your Spouse:

Name:_____

Address: _____

City:_____State:____Zip_____

Date of Birth:_____

Social Security #:_____

Phone Number:_____

Insurance Information of Your Spouse:
Company Name:_____
Group/Employer Name:_____
Member ID/Social SS#_____
Insurance Company Address:
_____
Phone #_____Payor ID:_____

I hereby authorize any insurance company to pay proceeds of any benefits due me directly to Timothy Ference D.D.S. A copy of this can be considered as an original for insurance purposes:

Signature:_____
Date:_____

Dental History:

Are having any dental problems?

- ☐ Yes
- ☐ No

If yes, are you having any pain or sensitivity?

- ☐ Yes Where: _____
- ☐ No

When was your last dental appointment? _____

What was done at that time?_____

Medical Health History:

Name of your Medical Doctor:

_____

Phone Number:_____

Date of your last exam:_____

Have you had any major medical problems and/or surgeries in the past 5 (five) years?

- ☐ Yes
- ☐ No

If yes, please provide details:

_____

_____

_____

Please list all medications and supplements you take: (A pre-printed list (if available) can be scanned into your record):_____

_____

_____

_____

_____

_____

Have you been instructed to take special medicine before dentistry?

- ☐ Yes
- ☐ No

If yes, what medication and for what reason?_____

Are you allergic to or sensitive to latex?

- ☐ Yes
- ☐ No

Have you ever had a serious allergic reaction or anaphylactic reaction to anything?

- ☐ Yes
- ☐ No

Do you carry an Epi-Pen?

- ☐ Yes
- ☐ No

Do you carry an inhaler?

- ☐ Yes
- ☐ No

Indicate which of the following conditions you currently have or have had in the past:

Choose Yes or No from the drop down menu.

No ADD/ADHD
No Allergy: LATEX
No Allergy: ASPIRIN
No Allergy: Erythromycin
No Allergy: PCN/AMOXICILLIN
No Allergy: CODEINE
No Allergy: Epinephrine
No Allergy: Sulfa
No Allergy: Anesthetic
No Allergy: Other DRUG_____
No Asthma
No Arthritis/RA
No Auto-Immune disease Type:_____
No Anxiety
No Autism
No Cancer: Type_____
No Cerebral Palsy
No Depression
No Diabetes
No Epilepsy/Seizures
No Excessive Bleeding/Clotting Disorder
No Glaucoma
No Hay Fever
No Hearing Problems
No Heart Disease
No Hepatitis Type:_____
No HPV/Human Papilloma
No Hodgkin's
No High Blood Pressure
No Low Blood Pressure
No Liver Disease
No Current known blood pressure:___/___
No Jaundice
No Kidney Disease
No MS
No Mitral Valve Prolapse
No Heart Valve surgery: When:_____
No On Birth Control:_____
No On Synthroid
No Orthopedic Joints -Where?_____
No Pacemaker
No Pregnant: Due Date:_____
No Pre-med
No Radiation Treatment
No Respiratory Problems
No Rheumatic Fever
No Sinus Problems
No Skin Cancer Type:_____
No Smokeless Tobacco Use
No Smoking: Amount per day:_____
No Speech Impairment
No Stroke
No Tuberculosis

Is there anything that needs further clarification or are there any other health issues you have that were not listed? If yes, please describe:_____

_____

_____

I have reviewed everything on this questionnaire and have responded accordingly. There are no other medical conditions and or allergies that have not been listed. I am aware I will be asked to update this information and am responsible for notifying Dr. Ference and staff of any changes.

Signature:_____

Date:_____