Jason D McCargar DMD, LTD

Getting to know you…

Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐

First Name: ___________________________ Last Name: __________________________

Social Security Number: __________________________

Your Date of Birth: ___________________

Your Address: ____

City: _________________ State: ________ Zip: _______________

Marital Status: ___________________________

Home Phone #: ____________________ Work #: ______________________

Cell Phone #: ______________________

Preferred e-mail address: ____

May we add you to our e-mail contact list? Yes ☐ No ☐

Where do you work? ____

What is your occupation? ____

Who do we have the pleasure of thanking for referring you? _______________________

____

Your family and interests….

Your Spouse/Partner: ____

Do you have any children or other dependents?: Yes ☐ No ☐

What are their names and ages? ____

____

What are your hobbies? ____

What is your favorite sports team? ____

What kind of music do you listen to? ____

Name the best restaurant in Scottsdale?____

What do you do to relax? ____

Please tell us about your Dental Insurance…

Your Primary Dental Insurance: ____

Group Number: ________________________________

Plan or Policy Number: __________________________

Insurance Address: ____

City: ____________________State: _________Zip: _______________

Number of Insurance Carrier: ____

Name of Insured: ____

Your relationship to the above Insured: ____

Date of Birth of Insured: ________________________
Social Security of Insured: _______________________
Insured's employer: ____

Your Secondary Dental Insurance…

Name of Insurance Carrier: ____
Group Number: ________________________________
Plan or Policy Number: __________________________
Insurance Address:____
City:_______________________ State:__________ Zip: ______________
Phone Number of Insurance Carrier: ____
Name of Insured:____
Your relationship to the above Insured: _______________________________________
Date of Birth of Insured: _________________________
Social Security of Insured: ________________________
Insured's employer: ____

Please tell us about today's visit to Scottsdale Dental Arts….

How can we serve you today? ____
____
When was the last time you went to the dentist?________________________________
Do you have any teeth that cause you pain?___________________________________
What do you like most about your smile?_____________________________________
What would you like to improve about your smile?_____________________________
____

Your Overall Health…

Are you under the care of a Physician? Yes ☐ No ☐
If so, what is your Physician's Name: ___________________________________
Practice address: ____
Practice phone number: ____
When was the last time you were seen by your Physician? _______________________
And for what purpose? ____
____
How would you describe your overall health?
☐ Excellent ☐ Fair
☐ Good ☐ Poor
Are you currently under care for a chronic condition? Yes ☐ No ☐
If so, please describe: ____
____

For Women:

Are you pregnant? Yes ☐ No ☐
Are you taking birth control? Yes ☐ No ☐
Are you nursing? Yes ☐ No ☐

Your medical history…

	Yes	No		Yes	No		Yes	No
Abnormal Bleeding	☐	☐	Fainting Spells	☐	☐	Nervous Problems	☐	☐
Alcohol/Drug Abuse	☐	☐	Frequent Headaches	☐	☐	Pacemaker	☐	☐
Anemia	☐	☐	Glaucoma	☐	☐	Psychiatric Disorders	☐	☐
Arthritis	☐	☐	Hay Fever	☐	☐	Radiation Therapy	☐	☐
Artificial Joints/Valves	☐	☐	Heart Attack	☐	☐	Respiratory Disease	☐	☐
Asthma	☐	☐	Heart Murmur	☐	☐	Rheumatic Fever	☐	☐
Blood Disease	☐	☐	Heart Surgery	☐	☐	Seizures	☐	☐
Blood Transfusion	☐	☐	Hemophilia	☐	☐	Shingles	☐	☐
Cancer	☐	☐	Hepatitis	☐	☐	Sickle Cell Disease	☐	☐
Chemotherapy	☐	☐	Herpes/Fever Blisters	☐	☐	Sinus Problems	☐	☐
Circulatory Problems	☐	☐	High Blood Pressure	☐	☐	Stroke	☐	☐
Colitis	☐	☐	HIV/AIDS	☐	☐	Swollen Feet/Ankles	☐	☐
Congenital Heart Disease	☐	☐	Hospitalized before?	☐	☐	Swollen Neck Glands	☐	☐
Cortisone Treatments	☐	☐	Jaundice	☐	☐	Thyroid Problems	☐	☐
Cough, persistent/bloody	☐	☐	Jaw Pain	☐	☐	Tonsillitis	☐	☐
Diabetes	☐	☐	Kidney Problems	☐	☐	Tuberculosis	☐	☐
Difficulty Breathing	☐	☐	Liver Disease	☐	☐	Tumor/Growth	☐	☐
Emphysema	☐	☐	Low Blood Pressure	☐	☐	Ulcers	☐	☐
Epilepsy	☐	☐	Mitral Valve Prolapse	☐	☐	Venereal Disease	☐	☐

Previous or current tobacco use? Yes ☐ No ☐

If yes, type and years of usage: ____

Are you aware of any serious medical conditions? Yes ☐ No ☐

Explain: ____

What medications are you currently taking? ____________________________________

____

Are you taking any over-the-counter or herbal remedies? _________________________

____

Do you have any drug allergies? ____

____

Do you have other allergies? ____

____

Have you ever had an adverse reaction to any of the following?

- ☐ Antibiotics
- ☐ Aspirin
- ☐ Codeine
- ☐ Dental anesthetics (Lidocaine/Novocain)
- ☐ Latex
- ☐ Penicillin
- ☐ Pain Medications
- ☐ Other _____________________

Are there any other conditions about your overall health that we should be informed about?

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