

# DENTAL ARTS



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	<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Problems	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol/Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joints/Valves	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Disease	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Shingles	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Herpes/Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory Problems	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Colitis	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Feet/Ankles	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Hospitalized before?	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Neck Glands	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone Treatments	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Cough, persistent/bloody	<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty Breathing	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tumor/Growth	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>

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?

- |  |   |
|--|---|
| <input type="checkbox"/> Antibiotics                             | <input type="checkbox"/> Latex            |
| <input type="checkbox"/> Aspirin                                 | <input type="checkbox"/> Penicillin       |
| <input type="checkbox"/> Codeine                                 | <input type="checkbox"/> Pain Medications |
| <input type="checkbox"/> Dental anesthetics (Lidocaine/Novocain) | <input type="checkbox"/> Other _____      |

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

\_\_\_\_\_

\_\_\_\_\_