Dr. Robert A. Bond and Dr. Renee M. Sellers
Welcome To Our Practice!

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Male ☐ Female

First Name | MI | Last Name | Preferred Name

Street Address | City | State | Zip

Social Security Number (optional) | Date of Birth | Home Phone | Daytime Phone

Email Address | Occupation | Spouse or Parent(s) Name

Person Financially Responsible, If Different From Above

Name | Phone | Social Security Number

Address | Date of Birth

Dental History

Former Dentist's Name | City, State

Reason for last dental visit | Approximate Date

My mouth is:
- ○ very comfortable
- ○ moderately comfortable
- ○ uncomfortable

I think I:
- ○ am in EXCELLENT oral health
- ○ am in GOOD oral health
- ○ am in POOR oral health

I desire:
- ○ excellent oral health
- ○ average or good oral health
- ○ crisis care only

I:
- ○ think the appearance of my mouth is excellent
- ○ think the appearance of my mouth is adequate
- ○ wish I could change the appearance of my mouth

I:
- ○ want to save my teeth at all costs
- ○ think the appearance of my mouth is excellent
- ○ wish I could change the appearance of my mouth

On a scale of 1 to 10, with 10 being the highest, please rate your fear of the dentist? _____

Is there anything we can do to help you feel more comfortable? _____

Are there any questions about dentistry you have never had adequately answered?

Medical History

Although dental personnel primarily treat the area in and around the mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____

Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No _____

Do you use tobacco? ◯ Yes ◯ No _____

Do you use controlled substances? ◯ Yes ◯ No _____

Have you ever been told you need pre-medication prior to a dental appointment? ◯ Yes ◯ No _____

Are you taking any medication, pills, or drugs? If yes, please list:

Women: Are you...

☐ Pregnant? ☐ Nursing?

☐ Taking oral contraceptives?

Are you allergic to any of the following:

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Sulfa ☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problem Bruise
- ☐ Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ Yellow Jaundice
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting Spells/Dizziness
- ☐ Frequent Cough
- ☐ Frequent Diarrhea
- ☐ Frequent Headaches
- ☐ Genital Herpes
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Heart Pace Maker
- ☐ Heart Trouble/Disease
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholestorol
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pain in Jaw Joints
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Sleep problems/Apnea
- ☐ Spina Bifada
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Venereal Disease

Have you ever had any serious illness or injury not listed above? ◯ Yes ◯ No If yes, please explain: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Dental INSURANCE INFORMATION

Primary Dental Insurance Information

Employer | Employer's Address | Work Phone

Name and Address of Primary Insurance Company

☐ M ☐ F

Insured's First Name | MI | Insured's Last Name

Insured's Identification Number | Group Number | Insured's Date of Birth

Patient Relationship to Insured

☐ Self ☐ Spouse ☐ Child ☐ Other

Patient Status

☐ Single ☐ Married ☐ Other ☐ Full Time Student ☐ Part Time Student ☐ Employed

Secondary Dental Insurance Information

Employer | Employer's Address | Work Phone

Name and Address of Secondary Insurance Company

☐ M ☐ F

Insured's First Name | MI | Insured's Last Name

Insured's Identification Number | Group Number | Insured's Date of Birth

Patient Relationship to Insured

☐ Self ☐ Spouse ☐ Child ☐ Other

Medical Insurance Information

Employer | Employer's Address | Work Phone

Name and Address of Primary Insurance Company

☐ M ☐ F

Insured's First Name | MI | Insured's Last Name

Insured's Identification Number | Group Number | Insured's Date of Birth

Please email the completed form to info@bonddental.net
We look forward to meeting you!