To the office of Matthew L. Logan, D.D.S.

Today's Date: _____

Name: _____ **I prefer to be called:** _____

Birth date:_____ Age: _____ Social Security #: _____

Home Address: _____

Home Phone #: _____ Cell Phone:_____ Work Phone #:_____ Drivers License #:_____

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

Other family members seen by us: _____

E-Mail Address:_____ Can We Contact and Confirm Appointments by E-Mail?_____

Employer: _____ How long there**?** _____ Occupation: _____

Employers Address**:** _____

Emergency contact not living with you

His/Her name:_____ Relation:_____ Work Phone #: _____ Home Phone #: _____

Address: _____

Person Responsible for Account if other than yourself

Name: _____ Relation:_____ Home Phone #:_____ Social Security #:_____

Employer: _____ Work Phone #: _____ Ext:_____ Drivers License #: _____

Billing Address: _____

SPOUSE INFORMATION

His/Her Name: _____ Birth date:_____ Social Security #:_____

Employer: _____ Work Phone #:_____ Ext:_____ Drivers License #:_____

INSURANCE INFORMATION

Primary insurance Dental Coverage? Yes No

Insurance Co. Name:_____ Phone #: _____ Group # (Plan, local or policy #): _____

Insurance Co. Address: _____

Insured's Name:_____ Insured's Social Security #:_____ Insured's Birth date:_____ Relation: _____

Insured's Employer: _____ Employer's Address: _____

Secondary Insurance Dental Coverage? Yes No

Insurance Co.Name:_____ Phone #: _____ Group # (Plan, local or policy #): _____

Insurance Co. Address: _____

Insured's Name:_____ Insured's Social Security #:_____ Insured's birth date:_____ Relation: _____

Insured's Employer: _____ Employers Address: _____

MEDICAL HISTORY

Do you have a personal physician? Yes No

Physician's Name: _____

Address: _____

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

Are you allergic to any of the following?

Y N Aspirin Y N Erythromycin Y N Sedatives

Y N Barbiturates Y N Jewelry Y N Sulfa Drugs

Y N Codeine Y N Latex Y N Tetracycline

Y N Dental Anesthetics Y N Penicillin Y N Other

Please list additional drugs that cause allergic reactions: _____

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

Are you pregnant? Unsure Yes No

Week #: _____ Are you nursing? Yes No

Are you taking any of the following?

Acetaminophen	Yes	No	Blood Thinners	Yes	No	Insulin/Diabetes Drugs	Yes	No	Thyroid Medicine	Yes	No
Antibiotics	Yes	No	Blood Pressure Medications	Yes	No	Nitroglycerin	Yes	No	Tranquilizers	Yes	No
Antihistamines	Yes	No	Recreational Drugs	Yes	No						
Asprin	Yes	No	Digitalis/Heart Medications	Yes	No	Steroids/Cortisone	Yes	No			

Are you taking any prescription/ over- the- counter-drugs not listed above? Yes No if yes, please list each one: _____

Do you or have you experienced the following?

Y N Abnormal Bleeding	Y N Headaches	Y N Liver Disease	Y N Shingles
Y N Alcohol Abuse	Y N Heart Attach	Y N Low Blood Pressure	Y N Sickle Cell Disease
Y N Anemia	Y N Diabetes	Y N Lupus	Y N Sinus Problems
Y N Arthritis	Y N Difficulty Breathing	Y N Heart Surgery	Y N Stroke
Y N Artificial Bones /Joints	Y N Drug Abuse	Y N Hemophilia	Y N Pace Maker
Y N Thyroid Problems	Y N Artificial valves	Y N Emphysema	Y N Hepatitis
Y N Asthma	Y N Epilepsy	Y N High Blood Pressure	Y N Psychiatric Problems
Y N Tuberculosis (TB)	Y N Fainting Spells	Y N Herpes	Y N Seizures
Y N Cancer	Y N Fever Blisters	Y N HIV+/AIDS	Y N Radiation Treatment
Y N Chemotherapy	Y N Glaucoma	Y N Hospitalized for any Reason	Y N Ulcers
Y N Kidney Problems			

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

DENTAL HISTORY

Why have you come to the dentist today?

Are you currently in pain? Yes No

Do you need to be premedicated before dental treatment? Yes No

Have you experienced problems associated with any previous dental work? Yes No

Do you now or have you ever experienced pain/ discomfort in your jaw joint (TMJ/TMD)? Yes No

Your current dental health is Good Fair Poor

Do you floss daily Yes No Brush daily? Yes No

Do you use anything in addition to your brush and floss? Yes No

If yes, what? _____

Do your gums ever bleed? Y N

Have you ever had periodontal disease? Y N

Do you have mobility in you teeth? Y N

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

Previous/Present Dentist: _____

Last visit date: _____

Why did you leave your previous dentist? _____

What did you like most and least about any dentist you have seen? _____

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

If not, what would you change? _____

AUTHORIZATION

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need. My method of payment will be _____

Signature: _____ Date: _____

PAYMENT IS DUE AT TIME OF SERVICE

I certify that I am covered by _____ Insurance Co. And I assign directly to Dr. _____ all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits, I authorize the use of this signature on all my insurance submissions, whether manual or electronic. _____

Thank you for choosing our office for you dental needs, if you have any friends or relatives in need of dental care, please let them know that new patients are always welcome here.

Dr. Matthew L. Logan DDS