Scott A. Welch DDS PA
COSMETIC & FAMILY DENTISTRY

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain optimal oral health.
Please fill out this form completely. The better we communicate, the better we can care for you.

About You

Today's Date: _____

E-mail Address: _____

Name: _____
Last First Middle ❑ Mr. ❑ Mrs. ❑ Mr. ❑ Dr.

I prefer to be called: _____ ❑ Male ❑ Female

Birthdate: _____ /_____ /_____ Age: _____ SS#: _____ - ____ - _____

Home Address: _____
Apt./Condo #

_____
City State Zip

❑ Single ❑ Married ❑ Partnered ❑ Divorced/Separated ❑ Widowed

Home Phone: _____ Cell/Other: _____

Work Phone: _____ Ext: _____

Driver's License #: _____

Employer: _____

Employer's Address: _____

_____
City State Zip

How long have you been there? _____

What is your occupation? _____

Where & when are best times to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

Previous/Present Dentist (Please Circle): _____

Person Responsible for Account: _____

Spouse Information

His/Her Name: _____

Employer: _____

Work Phone: _____ Ext: _____

Birthdate: _____ /_____ /_____ Age: _____ SS#: _____ - ____ - _____

Driver's License #: _____

Other Contact Information

Name of Relative or Friend not living with you: _____

Relation: _____

Home Phone: _____ Work Phone: _____

Primary Insurance Information

Primary Insurance Dental Coverage? ❑ Yes ❑ No

Insurance Company Name: _____

Insurance Company Address: _____

_____
City State Zip

Insurance Company Phone: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____

Relation: _____

Birthdate: _____ /_____ /_____ Age: _____ SS#: _____ - ____ - _____

Employer: _____

Employer's Address: _____

_____
City State Zip

Secondary Insurance Information

Secondary Insurance Dental Coverage? ❑ Yes ❑ No

Insurance Company Name: _____

Insurance Company Address: _____

_____
City State Zip

Insurance Company Phone: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____

Relation: _____

Birthdate: _____ /_____ /_____ Age: _____ SS#: _____ - ____ - _____

Employer: _____

Employer's Address: _____

_____
City State Zip

Payment is due in full at the time of treatment
unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature: _____ Date: _____ /_____ /_____

2016-D New Garden Road
Greensboro, NC 27410
www.DrScottWelch.com
336.288.4499

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Medical History

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name: _____

Physician's 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: _____

Physician's Phone: _____

Do you smoke or use tobacco in any other form? ❑ Yes ❑ No

Have you had any metal rods, pins or implants? ❑ Yes ❑ No

Are you taking any prescription/over-the-counter drugs? ❑ Yes ❑ No

Please list each one: _____

Have you ever taken Phen-Fen (Also known as Redux or Pondimin)? ❑ Yes ❑ No

If so, when? _____

WOMEN

Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No Week #: _____

Are you nursing? ❑ Yes ❑ No

Have you ever had any of the following diseases or medical problems (Please circle):

Y N Abnormal Bleeding/Hemophilia
Y N AIDS
Y N Alcohol/Drug Abuse
Y N Anemia
Y N Arthritis
Y N Artificial Bones/Joints/Valves
Y N Asthma
Y N Blood Transfusion
Y N Cancer/Chemotherapy
Y N Colitis
Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Emphysema
Y N Epilepsy
Y N Fainting Spells
Y N Frequent Headaches
Y N Glaucoma
Y N Hay Fever
Y N Heart Attack/Heart Surgery
Y N Heart Murmur
Y N Hepatitis
Y N Herpes/Fever Blisters
Y N High Blood Pressure
Y N HIV +
Y N Hospitalized for Any Reason
Y N Kidney Problems
Y N Liver Disease
Y N Low Blood Pressure
Y N Lupus
Y N Mitral Valve Prolapse
Y N Pacemaker
Y N Psychiatric Problems
Y N Radiation Treatment
Y N Rheumatic/Scarlet Fever
Y N Seizures
Y N Shingles
Y N Sickle Cell Disease/Traits
Y N Sinus Problems
Y N Stroke
Y N Thyroid Problems
Y N Tuberculosis (TB)
Y N Ulcers
Y N Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following (Please circle):

Y N Aspirin
Y N Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Jewelry/Metals
Y N Latex
Y N Penicillin
Y N Tetracycline
Y N Other

Please list any other drugs/materials that you are allergic to:

_____

_____

Medical History Update

Has there been any change in your health status since our last visit? ❑ Yes ❑ No

If Yes, please explain: _____

_____

Patient Signature: _____ Date: _____ /_____ /_____

Dentist Signature: _____ Date: _____ /_____ /_____

Dental History

Why have you come to the dentist today?: _____

_____

Are you currently in pain? ❑ Yes ❑ No

Do you require antibiotics before dental treatment? ❑ Yes ❑ No

Your current dental health is: ❑ Good ❑ Fair ❑ Poor

Have you ever had a serious/difficult problem associated with any previous dental work? ❑ Yes ❑ No

Do you floss daily? ❑ Yes ❑ No Brush daily? ❑ Yes ❑ No

Type of bristles on your toothbrush? ❑ Hard ❑ Medium ❑ Soft

Have you ever had gum treatment? ❑ Yes ❑ No

Do your gums ever bleed? ❑ Yes ❑ No Ever Itch? ❑ Yes ❑ No

Have you ever had periodontal disease? ❑ Yes ❑ No

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

Are your teeth sensitive to heat, cold, or anything else? ❑ Yes ❑ No

What are your teeth sensitive to? _____

Do you have any loose teeth? ❑ Yes ❑ No

Do you still have wisdom teeth? ❑ Yes ❑ No

Would you like fresher breath? ❑ Yes ❑ No

Would you like whiter teeth? ❑ Yes ❑ No

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

If not, what would you change? _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information 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 any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

Signature: _____ Date: _____ /_____ /_____

Office Use Only

I verbally reviewed the medical/dental information with the patient named herein.

Initials: _____ Date: _____ /_____ /_____

Doctor's Comments: _____

_____

_____

_____

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

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