Cole Dental
STEPHANIE J. MOWER, DMD
MICHAEL A. MOWER, DDS

Welcome

Name: _____ Preferred Name: _____

Birthdate: _____ Age: _____ Gender: Male Female

Please circle one

Social Security Number: _____ Marital Status: _____

Single, Married, Divorced, Widowed, Separated

Home Address: _____

Street City State Zip

Home Phone Number: _____ Cell Phone Number: _____

Email: _____ Best times to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us? _____

Employer: _____ Occupation: _____ How long there? _____

Employer Address: _____

Street City State Zip

Emergency Contact

Name: _____ Relation: _____ Phone Number: _____

Person Responsible for Account *(if other than yourself)*

Name: _____ Relation: _____ Phone Number: _____

Billing Address: _____

Street City State Zip

Social Security Number: _____ Employer: _____ Work Phone#: _____

Spouse Information

Name: _____ Birthdate: _____ Phone Number: _____

Billing Address: _____

Street City State Zip

Social Security Number: _____ Employer: _____

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Insurance Information

Primary Insurance

Name of Insured: _____ _____ _____
Last First MI

Insurance Plan Name: _____ ID #: _____ Group #: _____

Insured's Employer Name: _____

Employer Address: _____
Street City State Zip

Insured's Birth Date: _____

Patient's Relationship to insured: ☐ Self ☐ Spouse ☐ Child ○ Other

Secondary Insurance

Name of Insured: _____ _____ _____
Last First MI

Insurance Plan Name: _____ ID #: _____ Group #: _____

Insured's Employer Name: _____

Employer Address: _____
Street City State Zip

Insured's Birth Date: _____

Patient's Relationship to insured: ☐ Self ☐ Spouse ☐ Child ○ Other

If you do not have insurance coverage:

Are you interested in our Patient Loyalty Program (PLP)? ○Yes ☐ No

If you would like to join, or have questions regarding our plans our front desk team would be happy to help.

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Dental History

What's the purpose for your visit today? _____

Are you currently in pain? ◯ Yes ◯ No

Do you require antibiotics 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? ◯ Yes ◯ No

Your current dental health is? ◯ Good ◯ Fair ◯ Poor

Do you floss daily? ◯ Yes ◯ No

Do you brush daily? ◯ Yes ◯ No

Do you use anything in addition to your brush and floss? _____

Are you wanting to whiten your teeth? ◯ Yes ◯ No

Do your gums bleed? ◯ Yes ◯ No

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

Do you still have wisdom teeth? ◯ Yes ◯ No

Is there anything you would change about your current smile? _____

_____

Previous Dentist?_____

Medical History

Do you have a personal physician? ◯ Yes ◯ No Date of last visit:_____

Physician's Name: _____ Physician's Phone Number: _____

Your current physical health is? ◯ Good ◯ Fair ◯ Poor

Are you currently being treated for a medical condition?_____

_____

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

Have you ever taken Fosamax, or any other Bisphosphonate? ◯ Yes ◯ No If yes, IV or Oral? _____

Do you take a Blood Thinner? ◯ Yes ◯ No

Do you have a *SULFA* or *SULFITE* allergy? ◯ Sulfa allergy ◯ Sulfite allergy ◯ No allergy

For Women

Are you taking birth control pills? ◯ Yes ◯ NoAre you pregnant? ◯ Yes ◯ No ◯ Unsure

If yes, how many weeks? _____ Are you nursing? ◯ Yes ◯ No

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Current Medications

Please list any medications you are currently taking

Please list any allergies to medication: _____

_____

Do you OR have you experienced any of the following?

- ◯ ADD/ADHD
- ◯ A Fib
- ◯ Asthma
- ◯ Anxiety
- ◯ Arthritis
- ◯ Artificial Heart Valve
- ◯ Bleeding/Clotting Disorder
- ◯ Cancer
- ◯ Congenital Heart Defect
- ◯ Depression
- ◯ Diabetes (Type_____)
- ◯ Endocarditis
- ◯ Epilepsy
- ◯ GERD
- ◯ Heart Attack
- ◯ Heart Condition/ Surgeries _____ *Please Explain*
- ◯ Hepatitis (Type_____)
- ◯ High Blood Pressure
- ◯ High Cholesterol
- ◯ History of Drug Use
- ◯ HIV+/AIDS
- ◯ Long COVID
- ◯ Myocarditis
- ◯ Osteoporosis
- ◯ Pacemaker
- ◯ Respiratory Disease
- ◯ Stroke
- ◯ Tuberculosis
- ◯ Alzheimer's/Dementia/ Memory Issues

Please list any other existing or past conditions that are not listed above: _____

_____

Surgeries within the last 5 years, please list procedure, month & year: _____

_____

_____

Signature: _____ Date: _____

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