DR. G. MICHAEL MAITRE
DR. G. MICHAEL MAITRE, JR.

DR. FORREST CRABTREE
DR. R. BLANKENSHIP MAITRE

Today's date _____ E-mail Address: _____

Patient's Full Name: _____ I prefer to be called: _____ ☐ Male ☐ Female

Birthdate ___/___/___ Age: ____ Social Security #: _____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home Address: _____ City _____ State _____ Zip _____

Home Phone #: (____) _____ Pager/Car #: _____ Work Phone #: _____ Ext: ____ Driver's License #: _____

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

Employer: _____ Address _____

Spouse _____

Employer: _____ Address _____

Person responsible for payment: _____ Address _____

Parental Information (for minor or dependent child)

Mother's Name: _____ Social Security # _____

Wk. Phone #: (____) _____ Home Phone # (____) _____

Home Address: _____ City _____ State _____ Zip _____

Employer: _____ Address _____

Father's Name: _____ Social Security # _____

Wk. Phone #: (____) _____ Home Phone # (____) _____

Home Address: _____ City _____ State _____ Zip _____

Employer: _____ Address _____

Dental Insurance Information

Primary Dental Insurance Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____ Phone #: (____) _____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____

Insured's Name: _____ Insured's S. S. #: _____ Insured's D.O.B.: ___/___/___ Relation: _____

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

Secondary Dental Insurance Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____ Phone #: (____) _____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____

Insured's Name: _____ Insured's S. S. #: _____ Insured's D.O.B.: ___/___/___ Relation: _____

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

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

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

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

Do your gums bleed? ☐ Yes ☐ No Ever itch? ☐ Yes ☐ No

Have you ever had periodontal disease? ☐ Yes ☐ No

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

Do you have mobility in your teeth? ☐ Yes ☐ No

Do you still have wisdom teeth? ☐ Yes ☐ No

Previous / Present Dentist _____ Last Visit Date _____
(Please Circle)

Would you like fresher breath? ☐ Yes ☐ No Whiter teeth? ☐ Yes ☐ No

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

If not, what would you change? _____

_____

Medical History

Do you have a personal physician? ☐ Yes ☐ No

Phycisian'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 form? ☐ Yes ☐ No

Have you ever taken Phen-Fen, Redux or Pondimin? ☐ Yes ☐ No

For Women, Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant ☐ Unsure ☐ Yes ☐ No

Week # _____ Are you nursing? ☐ Yes ☐ No

Do you or have you experienced the following?

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

Please list any serious medical condition(s) that you have experienced? _____

Are you taking any prescription / over the counter drugs? ☐ Yes ☐ No If yes, please list each one: _____

_____

Are you allergic to any of the following?

Y N Aspirin	Y N Codeine	Y N Erythromycin	Y N Latex	Y N Sedatives	Y N Tetracycline
Y N Barbiturates	Y N Dental Anesthetics	Y N Jewelry / Metals	Y N Penicillin	Y N Sulfa Drugs	Y N Other

Please list anything additional that causes allergic reactions _____

_____

Print Patient's Name _____ Doctor's Signature _____

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need. I assign the Doctor all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover.

Signature _____ Date _____