

Patient Information

Date _____

Patient's name _____
Last First Middle

Name you wish to be called _____ Marital Status _____

Address _____
Street City Zip

Home # _____ Cell # _____

Birthdate _____ Social Security # _____

Driver's License # _____ Student _____ School _____

If Patient is a Minor, Give Parent's or Guardian's Name _____

How Did You Hear About Our Office? _____

What is the Purpose of this Visit? _____

Employer _____ Occupation _____

Work # _____ Ext. _____

Spouse's Name _____ Employer _____

Person to Contact in Case of Emergency _____

Relationship to Patient _____ Phone _____

Preferred Day for Appts _____ Time _____ AM _____ PM _____

Responsible Party Information

Name _____
Last First Middle

Residence _____
Street City Zip

Mailing Address _____
Street City Zip

Home # _____ Work # _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____

Spouse's Name _____ Employer _____

Social Security # _____ Birthdate _____ Work # _____

Please Indicate Below How You Prefer to Pay for Your Dental Treatment:

Cash _____ Debit/Credit Card _____ Personal Check _____ Dental Insurance _____

Dental Insurance Information

Insured's Name _____ Relationship to Patient _____

Birthdate _____ Social Security # _____

Insurance Co. _____ Tel. # _____ Grp. # _____

Policy / ID # _____

Insurance Co. Address _____ City _____ State _____ Zip _____

Do you have additional insurance? Yes _____ No _____

If yes. Complete the following:

Insured's Name _____ Social Security # _____

Name of Employer _____ Work # _____

Insurance Co. _____ Tel. # _____ Grp. # _____

Policy / ID # _____

Insurance Co. Address _____ City _____ State _____ Zip _____

MEDICAL HISTORY

Physician _____ Date of Last Visit _____
 Address _____ Phone _____

Please circle Yes or No (If Yes, please fill in the details)

- Yes No Are you taking any medication or aspirin? _____
 Yes No Are you taking any bone strengthening medication? _____
 Yes No Are you allergic to any medication? _____
 Yes No Do you have a history of a major illness? _____
 Yes No Have you had any major operations? _____
 Yes No Have you ever been involved in a serious accident? _____
 Yes No Have you been treated in the hospital in the past 2 years? ____ For _____
 Yes No If female: Are you taking hormones or birth control? ____ Are you pregnant or nursing? _____
 Yes No Have you ever had a blood test for hepatitis? ____ Were you vaccinated? _____

Please circle Yes or No if you have had or currently have any of the medical conditions below:

Heart Defect or Heart Murmur	Yes	No	Herpes	Yes	No
Congenital Heart Problems	Yes	No	HIV Positive	Yes	No
Endocarditis	Yes	No	Jaundice	Yes	No
Joint Replacement or Implant	Yes	No	Kidney Problems	Yes	No
Mitral Valve Prolapse	Yes	No	Nervous Disorders	Yes	No
Abnormal Bleeding/Hemophilia	Yes	No	Organ Transplant	Yes	No
Abnormal Blood Pressure	Yes	No	Pacemaker	Yes	No
AIDS	Yes	No	Pneumonia	Yes	No
Allergies	Yes	No	Prolonged Bleeding	Yes	No
Anemia	Yes	No	Prolonged Cough	Yes	No
Arthritis	Yes	No	Psychiatric Treatment	Yes	No
Asthma or Hayfever	Yes	No	Radiation Therapy	Yes	No
Bone Disorders	Yes	No	Rheumatic Fever	Yes	No
Chemotherapy	Yes	No	Sickle Cell Anemia	Yes	No
Diabetes	Yes	No	Stroke	Yes	No
Dizziness	Yes	No	Sinus Trouble	Yes	No
Drug Dependence	Yes	No	Thyroid Disease	Yes	No
Epilepsy	Yes	No	Tuberculosis	Yes	No
Fainting	Yes	No	Tumor or Cancer	Yes	No
Gastrointestinal Disorders	Yes	No	Ulcers	Yes	No
Glaucoma	Yes	No	Venereal Disease	Yes	No
Hepatitis	Yes	No			

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

DENTAL HISTORY

Previous Dentist _____ Date of last dental visit _____

What concerns you most about your teeth? _____

Yes No Are you presently in any dental pain? _____

Yes No Have you ever experienced any unfavorable reaction to dentistry? _____

Yes No Have you ever lost or chipped any teeth? _____

Yes No Have there been any injuries to your face, mouth or teeth? _____

Yes No Is any part of your mouth sensitive to temperature or pressure? _____

Yes No Do your gums bleed when you brush? _____

Yes No Do you have any type of thumb or tongue habit? _____

Yes No Are you a mouth breather? _____

Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____

Yes No Are you aware of your jaw clicking or popping? _____

Yes No Are you aware of clenching your teeth during the day? _____

Yes No Have you ever been told that you grind your teeth? _____

Yes No Do you have "tension" headaches? _____

Yes No Have you ever experienced chronic ringing in your ears? _____

Yes No Have you had cankers or cold sores on your lips, tongue, gums, or body? _____

Yes No Are you allergic to: Penicillin ____ Codeine ____ Local ____ Anesthetics ____ Other ____

Signature: _____ Date: _____