PATIENT INFORMATION

CONFIDENTIAL

(Please Print)

Name: _____ Birth date _____ SS#_____-_____-_____
First MI Last

Address: _____ City_____ State_____ Zip_____

E-mail Address: _____

Home Phone: _____ Cell # _____ Work # _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Other

Parent or Guardian's Name (if patient is a minor) _____

Patient or Parent/Guardian's Employer _____

Employer Address _____ City _____ State _____ Zip _____

If patient is a student, name of school/ college _____

Whom may we thank for referring you? _____

Emergency Contact & Relationship _____ Phone _____

RESPONSIBLE PARTY (if other than patient)

Name of Person Responsible for Account _____ Birth date _____

Relationship to Patient _____ Driver's License # _____

Address _____ City _____ State _____ Zip _____

Employer _____ Work # _____ Home # _____ Cell # _____

Is this person currently a patient in our office? ☐ YES ☐ NO

INSURANCE INFORMATION

Name of Subscriber _____ SS# _____-___-_____

Subscriber birth date ____/_____/19____ Relationship to Patient _____

Name of Employer _____ Work # _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Subscriber ID _____ Group # _____

Insurance Co. Address _____

Do you have any additional insurance? ☐ YES ☐ NO If yes, please complete the following:

Name of Subscriber _____ SS# _____-___-_____

Subscriber birth date ____/_____/19____ Relationship to Patient _____

Name of Employer _____ Work # _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Subscriber ID _____ Group # _____

Insurance Co. Address _____

X

Signature of patient or parent/ guardian **Date**

PATIENT MEDICAL HISTORY

Physician _____ Office Phone _____ Date of Last Exam _____

1. Are you under medical treatment now? ☐ YES ☐ NO

2. Have you ever been hospitalized for any Surgical operation or serious illness? ☐ YES ☐ NO

3. Are you taking any medication(s) including non-prescription? ☐ YES ☐ NO
   If yes, what medication(s) are you taking? _____
   _____

4. Do you use tobacco? ☐ YES ☐ NO

5. Do you use alcohol? ☐ YES ☐ NO
   If yes, how many drinks per week? _____

6. Do you use cocaine or other drugs? ☐ YES ☐ NO

7. Are you allergic or have you had reactions to the following? **If NONE apply, please initial here:** _____

   ☐ Local Anesthetic w/ Epinephrine
   ☐ Penicillin
   ☐ Sulfa Drugs
   ☐ Sedatives
   ☐ Other(s) _____
   ☐ Barbiturates
   ☐ Other Antibiotic(s) _____
   ☐ Aspirin
   ☐ Iodine

8. FEMALE ONLY:
   a. Are you pregnant or think you may be pregnant? ☐ YES ☐ NO
   b. Are you nursing? ☐ YES ☐ NO
   c. Are you taking birth control pills or other hormones? ☐ YES ☐ NO

9. Do you have or have you had any of the following?
   Please check all that apply. **If NONE apply, please initial here:** _____

☐ High Blood Pressure	☐ Heart Disease	☐ Chest Pains
☐ Heart Attack	☐ Cardiac Pacemaker	☐ Easily Winded
☐ Rheumatic Fever	☐ Heart Murmur	☐ Stroke
☐ Swollen Ankles	☐ Angina	☐ Allergies
☐ Hay Fever	☐ Fainting	☐ Seizures
☐ Frequently Tired	☐ Tuberculosis	☐ HIV / AIDS
☐ Asthma	☐ Anemia	☐ Low Blood Pressure
☐ Radiation Therapy	☐ Cancer	☐ Leukemia
☐ Emphysema	☐ Glaucoma	☐ Epilepsy
☐ Convulsions	☐ Recent Weight Loss	☐ Arthritis
☐ Liver Disease	☐ Diabetes	☐ Mitral Valve Prolapse
☐ Joint Replacement/ Implant	☐ Kidney Disease	☐ Hepatitis
☐ Jaundice	☐ Respiratory Problems	☐ Thyroid Problem
☐ Sexually Transmitted Disease	☐ Stomach Ulcers	☐ Stomach Troubles

☐ Other _____

Dentist and Hygienist Comments: _____

PATIENT DENTAL HISTORY

Please check all that apply.

☐ My gums bleed while brushing or flossing.
☐ My teeth are sensitive to sweet/ sour liquids/ foods.
☐ I have sores or lumps in or near my mouth.
☐ I have experienced jaw related problems:
   ☐ clicking.
   ☐ pain (joint, ear, side or face).
   ☐ difficulty in opening or closing.
   ☐ difficulty in chewing.
☐ I have been instructed on the correct method of brushing my teeth.
☐ I have been instructed on proper gum care.
☐ My teeth are sensitive to hot or cold liquids.
☐ I feel pain to one or more teeth
☐ I have had head, neck or jaw injuries.
☐ I clench or grind my teeth.
☐ I frequently bite my lips and/or cheeks.
☐ I have had difficult extractions in the past.
☐ I have had orthodontic work.
☐ I have frequent headaches.
☐ I have experienced prolonged bleeding following extractions.

Last Dental Visit: _____

Are you happy with your smile? _____

X _____

Signature of patient or parent/ guardian **Date**