PATIENT INFORMATION

CONFIDENTIAL

(PLEASE PRINT)

PATIENT # ____________________

DATE ____________________

NAME ______________________________ (FIRST M LAST) BIRTHDATE ______________ ☐ MALE ☐ FEMALE

ADDRESS ______________________________ CITY ______________ STATE ______ ZIP ______

E-MAIL ______________ CELL PHONE ______________ HOME PHONE ______________

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

NAME OF EMPLOYER/SCHOOL ______________________________ WORK/SCHOOL PHONE ______________

EMPLOYER/SCHOOL ADDRESS ______________________________ CITY ______________ STATE ______ ZIP ______

WHOM MAY WE THANK FOR REFERRING YOU? ______________________________

PERSON TO CONTACT IN CASE OF AN EMERGENCY ______________________________ PHONE ______________

RESPONSIBLE PARTY

☐ SAME AS ABOVE

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT ______________________________ RELATIONSHIP TO PATIENT ______________

ADDRESS (IF DIFFERENT) ______________________________ CITY ______________ STATE ______ ZIP ______

E-MAIL ______________ HOME PHONE ______________ CELL PHONE ______________

DRIVER'S LICENSE # ______________________________ BIRTHDATE ______________

EMPLOYER ______________________________ WORK PHONE ______________

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED ______________________________ RELATIONSHIP TO PATIENT ______________

BIRTHDATE ______________ SS # ______________ DATE EMPLOYED ______________

NAME OF EMPLOYER ______________________________ WORK PHONE ______________

ADDRESS OF EMPLOYER ______________________________ CITY ______________ STATE ______ ZIP ______

INSURANCE COMPANY ______________________________ GROUP # ______________ UNION OR LOCAL # ______________

INS. CO. ADDRESS ______________________________ CITY ______________ STATE ______ ZIP ______

HOW MUCH IS YOUR DEDUCTIBLE? ______ HOW MUCH HAVE YOU USED? ______ MAX. ANNUAL BENEFIT? ______

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED ______________________________ RELATIONSHIP TO PATIENT ______________

BIRTHDATE ______________ SS # ______________ DATE EMPLOYED ______________

NAME OF EMPLOYER ______________________________ WORK PHONE ______________

ADDRESS OF EMPLOYER ______________________________ CITY ______________ STATE ______ ZIP ______

INSURANCE COMPANY ______________________________ GROUP # ______________ UNION OR LOCAL # ______________

INS. CO. ADDRESS ______________________________ CITY ______________ STATE ______ ZIP ______

HOW MUCH IS YOUR DEDUCTIBLE? ______ HOW MUCH HAVE YOU USED? ______ MAX. ANNUAL BENEFIT? ______

X ______________________________

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

SIGNATURE

PATIENT NAME ______ TODAY'S DATE ______

HOME ADDRESS ______ DATE OF BIRTH ______

______ HOME PHONE ______

BUSINESS ADDRESS ______ BUSINESS PHONE ______

______ SOC. SEC. NO. ______

PATIENT NAME

PATIENT MEDICAL HISTORY

PHYSICIAN ______ OFFICE PHONE ______ DATE OF LAST EXAM ______

	YES	NO
1. ARE YOU UNDER MEDICAL TREATMENT NOW?	☐	☐
2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS?	☐	☐
3. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE?	☐	☐

IF YES, WHAT MEDICATION(S) ARE YOU TAKING? ______

______

	YES	NO
4. DO YOU USE TOBACCO?	☐	☐
5. DO YOU USE ALCOHOL, COCAINE OR OTHER DRUGS?	☐	☐
6. ARE YOU WEARING CONTACT LENSES?	☐	☐

7. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING?

YES	NO		YES	NO		YES	NO	
☐	☐	LOCAL ANESTHETICS (E.G. NOVOCAINE)	☐	☐	BARBITURATES	☐	☐	ASPIRIN
☐	☐	PENICILLIN OR OTHER ANTIBIOTICS	☐	☐	SEDATIVES	☐	☐	OTHER ______
☐	☐	SULFA DRUGS	☐	☐	IODINE			______

8. WOMEN ONLY:

	YES	NO
A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?	☐	☐
B) ARE YOU NURSING?	☐	☐
C) ARE YOU TAKING BIRTH CONTROL PILLS?	☐	☐

9. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

YES	NO		YES	NO		YES	NO	
☐	☐	HIGH BLOOD PRESSURE	☐	☐	HEART DISEASE	☐	☐	CHEST PAINS
☐	☐	HEART ATTACK	☐	☐	CARDIAC PACEMAKER	☐	☐	EASILY WINDED
☐	☐	RHEUMATIC FEVER	☐	☐	HEART MURMUR	☐	☐	STROKE
☐	☐	SWOLLEN ANKLES	☐	☐	ANGINA	☐	☐	HAY FEVER / ALLERGIES
☐	☐	FAINTING / SEIZURES	☐	☐	FREQUENTLY TIRED	☐	☐	TUBERCULOSIS
☐	☐	ASTHMA	☐	☐	ANEMIA	☐	☐	RADIATION THERAPY
☐	☐	LOW BLOOD PRESSURE	☐	☐	EMPHYSEMA	☐	☐	GLAUCOMA
☐	☐	EPILEPSY / CONVULSIONS	☐	☐	CANCER	☐	☐	RECENT WEIGHT LOSS
☐	☐	LEUKEMIA	☐	☐	ARTHRITIS	☐	☐	LIVER DISEASE
☐	☐	DIABETES	☐	☐	JOINT REPLACEMENT OR IMPLANT	☐	☐	HEART TROUBLE
☐	☐	KIDNEY DISEASES	☐	☐	HEPATITIS / JAUNDICE	☐	☐	RESPIRATORY PROBLEMS
☐	☐	AIDS OR HIV INFECTION	☐	☐	SEXUALLY TRANSMITTED DISEASE	☐	☐	OTHER ______
☐	☐	THYROID PROBLEM	☐	☐	STOMACH TROUBLES / ULCERS			______

COMMENTS

______

______

______

______

______

SIGNATURE OF DENTIST ______ DATE ______

PATIENT DENTAL HISTORY

	YES	NO
1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?	☐	☐
2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS?	☐	☐
3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS?	☐	☐
4. DO YOU FEEL PAIN TO ANY OF YOUR TEETH?	☐	☐
5. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?	☐	☐
6. HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES?	☐	☐
7. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?		
A) CLICKING?	☐	☐
B) PAIN (JOINT, EAR, SIDE OF FACE)?	☐	☐
C) DIFFICULTY IN OPENING OR CLOSING?	☐	☐
D) DIFFICULTY IN CHEWING?	☐	☐
8. DO YOU HAVE FREQUENT HEADACHES?	☐	☐
9. DO YOU CLENCH OR GRIND YOUR TEETH?	☐	☐
10. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY?	☐	☐
11. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST?	☐	☐
12. HAVE YOU HAD ANY ORTHODONTIC WORK?	☐	☐
13. HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS?	☐	☐
14. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING YOUR TEETH?	☐	☐
15. HAVE YOU EVER HAD INSTRUCTIONS ON THE CARE OF YOUR GUMS?	☐	☐

SIGNATURE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. TO THE BEST OF MY KNOWLEDGE, THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH.

X ______ ______

PATIENT, PARENT OR GUARDIAN DATE