# PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form to the best of your ability. If you have any questions we'll be glad to help you.

## PERSONAL

Name_____
Last First MI (Preferred)

Birthdate_____ SS#_____ Gender: [ ] M [ ] F Marital Status _____
Work Phone _____ Wireless Phone _____
Home Phone _____ E-mail _____

| | | | | |
|---|---|---|---|---|
| Preferred contact method | [ ] HmPhone | [ ] WkPhone | [ ] WirelessPh | [ ] Email |
| Preferred contact method for confirmations | [ ] HmPhone | [ ] WkPhone | [ ] WirelessPh | [ ] Email |
| Preferred contact method for recall | [ ] HmPhone | [ ] WkPhone | [ ] WirelessPh | [ ] Email |
| Student status if dependent over 19 (for ins) | [ ] Nonstudent | [ ] Fulltime | [ ] Parttime | |

How did you hear about us?
_____
(If someone referred you here, please write down their name so we can thank them.)

## ADDRESS

Check box if same for entire family [ ]
Address_____
Apt or Suite _____ City_____ State _____ Zip_____

## INSURANCE

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child
Subscriber Name_____ Subscriber ID # _____
Insurance Company _____ Phone_____
Employer_____ Group Name_____ Group #_____

## DENTAL HISTORY

CHIEF ORAL COMPLAINT _____ DATE OF LAST DENTAL EXAM _____
Any previous major dental treatment ❑ YES ❑NO WHEN _____

DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING – INDICATE WITH A (✓)

- ❑ Teeth sensitive to cold, heat, sweets or pressure
- ❑ Bleeding gums. How long _____
- ❑ Food impaction
- ❑ Clenching or grinding
- ❑ Burning of tongue
- ❑ Swelling or lumps in mouth
- ❑ Frequent blisters on lips or mouth
- ❑ Pain around ear
- ❑ Unusual sounds in ear while eating
- ❑ Texture of toothbrush _____
- ❑ Frequency of brushing _____
- ❑ Disclosing tablets or solution
- ❑ Fluoride supplements
- ❑ Bad breath
- ❑ Unpleasant taste
- ❑ Unfavorable dental experience
- ❑ Complications from extractions
- ❑ Periodontal treatment
- ❑ Orthodontic treatment
- ❑ Mouth breathing
- ❑ Oral habits i.e. fingernail biting, cheek biting, etc.
- ❑ Cigarettes, pipe, or cigar smoking
- ❑ Frequency of flossing _____
- ❑ Inter dental stimulators
- ❑ Water jet device
- ❑ Alcohol

## MEDICAL HISTORY

PHYSICIAN'S NAME _____ DATE OF LAST PHYSICAL EXAM _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING – INDICATE WITH A (✓)

- ❑ Allergies to drugs
- ❑ Allergies to anesthetics
- ❑ Any heart ailments
- ❑ High blood pressure
- ❑ Neurological problems
- ❑ Radiation treatments
- ❑ Excessive bleeding from cut or extraction
- ❑ Anemia or blood problems
- ❑ Arthritis
- ❑ Chronic Fatigue Syndrome
- ❑ Immune System Disorders (AIDS, HIV, ARC)
- ❑ Thyroid
- ❑ Tonsillitis
- ❑ Ulcer or colitis
- ❑ Venereal disease
- ❑ Asthma
- ❑ Hay fever or allergies in general
- ❑ Diabetes
- ❑ Kidney problems
- ❑ Latex sensitivity
- ❑ Liver problems or hepatitis
- ❑ Malignancies
- ❑ Psychiatric care/emotional problems
- ❑ Rheumatic fever
- ❑ Sinus problems
- ❑ Stroke
- ❑ Eye disorders
- ❑ Tuberculosis
- ❑ Pregnancy, if so what month _____
- ❑ Other _____

Signature _____ Date _____