

Date _____

Confidential Patient Information

ABC

Patient's Name _____ Marital Status _____
Last First Middle

Address _____
Street City State ZIP

Telephone # Home: _____ Work: _____ Cell: _____ Birthdate _____ Social Security # _____

If patient is a minor, give parent's or guardian's name _____

Whom may we thank for referring you to our office? _____

Confidential Responsible Party Information

Name _____ Marital Status _____
Last First Middle

Residence _____
Street City State ZIP

How long at this address _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 yrs.) _____
Street City State Zip

Social Security # _____ Driver's License # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____
Last First Middle

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Insurance Information

Policy Holder's name _____ Social Security # _____ Date of Birth _____

Insurance Company _____ Group No. _____ Policy # _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

Do you have dual coverage? No Yes If yes:

Policy Holder's name _____ Social Security # _____ Date of Birth _____

Insurance Company _____ Group No. _____ Policy # _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____ Relationship: _____

I understand that where appropriate, credit bureau reports may be obtained. If I cancel/reschedule my appointment in less than 24 working hours, I will pay \$25 for every 30 minutes of scheduled time.

Signature (parent's signature if minor) _____
Updates (date & initial) _____

Dental History

Why have you come to the dentist today? _____

Are you currently in pain? Yes No

Have you ever had a serious / difficult problem associated with any previous dental work? Yes No

Have you ever had gum treatment? Yes No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? Yes No

Do you like your smile? Yes No

How many times a week do you floss? _____

How many times a day do you brush? _____ How long do you use a tooth brush before replacing it? _____

Type of bristles? Hard Medium Soft

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

Have you lost any teeth? Yes No If yes, why? _____

Medical History

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 other form? Yes No If yes, how much for how long? _____

Are you taking any prescription / over-the-counter drugs? Yes No

Please list each one _____

For Women: Are you taking birth control pills? Yes No Are you pregnant? Yes No Week #: _____

Are you nursing? Yes No

Have you ever had any of the following diseases or medical problems?

Anemia ----- Yes No
 High / Low Blood Pressure ----- Yes No
 Heart Attack / Stroke ----- Yes No
 Heart Surgery / Pacemaker ----- Yes No
 Heart Murmur ----- Yes No
 Congenital Heart Defect ----- Yes No
 Mitral Valve Prolapse (MVP) ----- Yes No
 Rheumatic / Scarlet Fever ----- Yes No
 Epilepsy / Seizures ----- Yes No
 Fainting Spells ----- Yes No
 Diabetes ----- Yes No
 Tuberculosis (TB) ----- Yes No
 Artificial Bones / Joint ----- Yes No
 Artificial Valves ----- Yes No
 Difficulty Breathing / Emphysema ----- Yes No
 Asthma ----- Yes No

Arthritis ----- Yes No
 Glaucoma ----- Yes No
 Hepatitis ----- Yes No
 Blood Transfusion ----- Yes No
 Hemophilia / Abnormal Bleeding ----- Yes No
 Cancer / Chemotherapy / Radiation Treatment Yes No
 HIV + / AIDS ----- Yes No
 Kidney Problems ----- Yes No
 Fever Blisters / Herpes ----- Yes No
 Shingles ----- Yes No
 Venereal Disease ----- Yes No
 Drug / Alcohol Abuse ----- Yes No
 Ulcers / Colitis ----- Yes No
 Severe / Frequent headaches ----- Yes No
 Psychiatric Problems ----- Yes No
 Sinus Problems ----- Yes No
 Hospitalized for Any Reason ----- Yes No

Are you allergic to any of the following?

Aspirin <input type="checkbox"/> Yes <input type="checkbox"/> No Codeine <input type="checkbox"/> Yes <input type="checkbox"/> No Dental Anesthetics <input type="checkbox"/> Yes <input type="checkbox"/> No	Erythromycin <input type="checkbox"/> Yes <input type="checkbox"/> No Tetracycline <input type="checkbox"/> Yes <input type="checkbox"/> No Penicillin <input type="checkbox"/> Yes <input type="checkbox"/> No	Latex <input type="checkbox"/> Yes <input type="checkbox"/> No Any Metal / Plastic <input type="checkbox"/> Yes <input type="checkbox"/> No Other <input type="checkbox"/> Yes <input type="checkbox"/> No
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Please list any other drugs that you are allergic to: _____