Today's Date ____________

Patient Information

Name ______________________ Date of Birth ____________ Sex ________

Address ______________________ City, State, Zip ______________________

Home Phone ____________ Work Phone ____________ Cell Phone ____________

E-mail ______________________

Check Appropriate Box **Minor** ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Other** ☐

Responsible Party Information

Name ______________________ Social Security # ____________

Address ______________________ City, State, Zip ______________________

E-mail ____________ Preferred Phone ____________ Work Phone ____________

Occupation ______________________ Employer ______________________

Dental Insurance Information

Insurance Company ______________________ Insured Name: ____________

Insured DOB: ____________ Relationship to Patient ______________________

Subscriber # ____________ Group # ____________ Employer ____________

Insurance Co. Address ______________________ Phone ____________

Secondary Dental Insurance Information

Insurance Company ______________________ Insured Name ____________

Insured DOB ____________ Relationship to Patient ______________________

Subscriber # ____________ Group # ____________ Employer ____________

Insurance Co. Address ______________________ Phone ____________

Patient Medical History

General Health **Good** ☐ **Fair** ☐ **Poor** ☐

Physician ____________ Office Phone ____________ Date of Last Exam ____________

Are you currently on any prescriptions or over the counter medications, vitamins, nutritional, or herbal supplements? If so, please list medications below. **Yes** ☐ **No** ☐

____

Are you allergic to Novocaine, local, or general anesthetics? If so, please explain below. **Yes** ☐ **No** ☐

____

Are you allergic to any other medications? If so, please list below. **Yes** ☐ **No** ☐

____

Are you allergic to any of the following:

☐ Latex ☐ Aspirin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Sulfa Drugs ☐ Metal

Please mark the ones that apply to you:

- ☐ Had a serious illness or operation?
- ☐ Had a blood transfusion?
- ☐ Undergone radiation or chemotherapy?
- ☐ Use or have used tobacco products?
- ☐ Recent unusual weight loss?
- ☐ Excessive thirst and/or urination?
- ☐ Family history of diabetes?
- ☐ Subject to fainting?

Women: Are you

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Please circle Y or N for each of the following (you must choose one):

Y	**N**	Anemia	**Y**	**N**	Diabetes	**Y**	**N**	Kidney disease
Y	**N**	Arthritis, Rheumatism	**Y**	**N**	Emphysema	**Y**	**N**	Low blood pressure
Y	**N**	Artificial heart valves	**Y**	**N**	Epilepsy	**Y**	**N**	Mitral valve prolapse
Y	**N**	Artificial joints	**Y**	**N**	Glaucoma	**Y**	**N**	Osteoporosis
Y	**N**	Asthma	**Y**	**N**	Headaches	**Y**	**N**	Pacemaker
Y	**N**	Abnormal bleeding	**Y**	**N**	Heart murmur	**Y**	**N**	Scarlet Fever
Y	**N**	Blood disease	**Y**	**N**	Heart problems	**Y**	**N**	Sickle cell anemia
Y	**N**	Cancer	**Y**	**N**	Hepatitis type	**Y**	**N**	Stroke
Y	**N**	Chemical dependency	**Y**	**N**	Herpes	**Y**	**N**	Swelling of feet or ankles
Y	**N**	Circulatory problems	**Y**	**N**	High blood pressure	**Y**	**N**	Thyroid problems
Y	**N**	Cortisone treatments	**Y**	**N**	Immune deficiency	**Y**	**N**	Tuberculosis
Y	**N**	Cough	**Y**	**N**	Jaundice	**Y**	**N**	Ulcer

Do you have any other medical or health condition which is not listed? If so, please list below:

____

Dental History

Name of Last Dentist ______________________________ Last Visit? __________

Reason for today's visit? ______________________________

Have you ever had a serious problem from a previous dental treatment? **Yes** ☐ **No** ☐

If yes, please explain: ______________________________

How often do you brush? __________ How often do you floss? __________ How often do get cleanings? __________

Please mark the ones that apply to you:

- ☐ Hesitant to come to the dentist
- ☐ Gums bleed during brushing and flossing
- ☐ Have a bad odor or taste in mouth
- ☐ Food frequently gets stuck in teeth
- ☐ Have fillings you don't like
- ☐ Snore or have trouble sleeping
- ☐ Would like whiter teeth
- ☐ Would like straighter teeth
- ☐ Have missing teeth you would like replaced
- ☐ Have loose dentures or partials

Is there anything you don't like about your smile? ______________________________

Authorization and Release

I have read and answered the above questions to the best of my knowledge.

Patient/Guardian Signature ______________________________ Date ______

Reviewed by: ______________________________ Date ______