PATIENT INFORMATION	CONFIDENTIAL
NAME ____	BIRTHDATE ________________________
ADDRESS ____	HOME PHONE ______________________
CITY _______________________________ STATE _____________ ZIP _____________	CIRCLE APPROPRIATE SELECTION: MINOR SINGLE MARRIED DIVORCED WIDOWED SEPERATED
PATIENT OR PARENT'S EMPLOYER ____	WORK PHONE ______________________
BUSINESS ADDRESS ____	CELL PHONE ________________________
CITY ______________________________ STATE ______________ ZIP ______________	OTHER ____________________________
IF PT IS A STUDENT, NAME OF SCHOOL ____________________________________	EMAIL ____________________________
CITY ____ STATE _______________	
WHOM MAY WE THANK FOR REFERRING YOU? __________________________ ____	
RESPONSIBLE PARTY	

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT ____ ____ ADDRESS ____ CITY ____ STATE ____ ZIP ____ EMPLOYER ____ ADDRESS ____ CITY ____ STATE ____ ZIP ____	RELATIONSHIP TO PATIENT ____ HOME PHONE ____ WORK PHONE ____ CELL PHONE ____ BIRTHDATE ____ SS NUMBER ____
INSURANCE INFORMATION	
NAME OF INSURED ____ INSURANCE COMPANY ____ ADDRESS ____ CITY ____ STATE ____ ZIP ____ PATIENT NAME ____	RELATIONSHIP TO PATIENT ____ BIRTHDATE ____ SS NUMBER ____ GROUP NUMBER ____ INSURANCE PHONE ____ PAGE 2
ADDITIONAL INSURANCE	

NAME OF INSURED ____

RELATIONSHIP TO PATIENT __________

INSURANCE COMPANY ____

BIRTHDATE _________________________

ADDRESS ____

SS NUMBER _________________________

CITY _____________________________ STATE _________________ ZIP ___________

GROUP NUMBER ____________________

INSURANCE PHONE _________________

PATIENT MEDICAL HISTORY

PHYSICIAN NAME ____

PHYSICIAN PHONE __________________

- ARE YOU UNDER THE CARE OF A PHYSICIAN YES NO
- HAVE YOU BEEN HOSPITALIZED IN THE LAST FIVE YEARS YES NO
- ARE YOU TAKING MEDICATIONS? INCLUDING OVER THE COUNTER AND PRESCRIPTION. YES NO
- DO YOU USE TOBACCO? YES NO
- DO YOU USE ALCOHOL? YES NO
- DO YOU USE COCAINE OR OTHER DRUGS? YES NO
- DO YOU WEAR CONTACTS? YES NO
- DO YOU HAVE ANY ALLERGIES? YES NO
  ____
  ____
- HAVE YOU EVER HAD A REACTION TO ANESTHETIC? YES NO

EXPLAIN ABOVE: ____
____
____

DATE OF LAST EXAM _________________

WOMEN ONLY:

- ARE YOU PREGNANT _________
- ARE YOU NURSING __________
- ARE YOU TAING BIRTH CONTROL PILLS ______________

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS ABOUT YOURSELF: YES NO YES NO	(*MARK ALL ANSWERS WITH A YES OR NO)* YES NO
HIGH BLOOD PRESSURE ___ ___ FREQUENTLY TIRED ___ ___ HEART ATTACK ___ ___ ANEMIA ___ ___ RHEUMATIC FEVER ___ ___ EMPHYSEMA ___ ___ SWOLLEN ANKLES ___ ___ CANCER ___ ___ FAINING/SEIZURES ___ ___ ARTHRITIS ___ ___ ASTHMA ___ ___ JOINT REPLACEMENT ___ ___ LOW BLOOD PRESSURE ___ ___ CHEST PAINS ___ ___ EPILEPSY/CONVULSIONS ___ ___ SHORT OF BREATH ___ ___ LEUKEMIA ___ ___ STROKE ___ ___ DIABETES ___ ___ HAY FEVER/ALLERGIES ___ ___ HEART DISEASE ___ ___ TUBERCULOSIS ___ ___ CARDIAC PACE MAKER ___ ___ RADIATION THERAPY ___ ___ HEART MURMER ___ ___ GLAUCOMA ___ ___ ANGINA ___ ___ LIVER DISEASE ___ ___	KIDNEY DISEASE ___ ___ AIDS/HIV INFECTION ___ ___ STD'S ___ ___ THYROID PROBLEMS ___ ___ HEPATITIS A, B OR C ___ ___ ULCERS ___ ___ RESPIRATORY PROBLEMS ___ ___ OTHER ________________________________ ____ ____ ____ ____ ____
PATIENT NAME ____	PAGE 3
PATIENT DENTAL HISTORY	

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 IN ANY OF YOUR TEETH?
5. DO YOU HAVE ANY SORES OR LUMPS IN YOUR MOUTH?
6. HAVE YOU EVER SUFFERED TRAUMA TO YOUR FACE MOUTH OR JAW?
7. DOES YOUR JAW EVER CLICK, POP, CRACKLE OR ACHE?
8. DO YOU HAVE PAIN IN YOUR JAW JOINT, EAR OR SIDE OF THE FACE?
9. DO YOU HAVE DIFFICULTY OPENING OR CLOSING YOUR MOUTH?
10. DO YOU HAVE DIFFICULTY CHEWING?
11. DO YOU HAVE FREQUENT HEADACHES?
12. DO YOU CLENCH OR GRIND YOUR TEETH?
13. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY?
14. HAVE YOU HAD PROBLEMS WITH PREVIOUS DENTAL WORK?
15. HAVE YOU EVER HAD BRACES?
16. HOW MANY TIMES A DAY DO YOU BRUSH YOUR TEETH?
17. HOW OFTEN DO YOU FLOSS?
18. DO YOU USE A MANUAL BRUSH OR ELECTRIC?
19. DO YOU USE ANY TYPE OF MOUTH RINSE?

GOALS FOR YOUR MOUTH, TEETH AND SMILE:

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD THAT BE?

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been answered accurately. I understand that providing false or incorrect information can be dangerous to my health. PATIENT SIGNATURE DATE PRINT NAME	DENTIST SIGNATURE DATE WITNESS SIGNATURE DATE