Patient Information

Patient Name_____ Date:_____
Last First MI

Address _____
Street Apartment #

_____
City State Zip Code

SS# ___ - ___ - ___ DOB_____ DL#_____ State_____

Home#_____Work# _____ Ext:_____

Cell#_____ Email Address_____

□ Married □ Single □ Child □ Other □ Male □ Female

Emergency Contact (other than spouse) Name_____ Phone#(____)_____

Address _____Relationship_____

Referral Information

Whom may we thank for referring you to our practice? □ Another patient, **friend** □ Another patient, **relative**

□ Another Dental Office □ Yellow Pages.com □ Internet □ Facebook □ School □ Work □ Other_____

Name of person or office referring you to our practice:_____

Insurance Information

MEDICAL INSURANCE

Name of Insured_____ Are you the insured? ☐ Yes ☐ No
Last First MI

Insurance Plan Name and Address: _____

Insurance Phone #_____ Employer Name_____

Insured's DOB_____ ID#_____ Group#_____

Relationship to patient: □ Self □ Spouse □ Parent □ Other_____

PRIMARY DENTAL INSURANCE

Name of Insured_____ Are you the insured? ☐ Yes ☐ No
Last First MI

Insurance Plan Name and Address: _____

Insurance Phone #_____ Employer Name_____

Insured's DOB_____ ID#_____ Group#_____

Relationship to patient: □ Self □ Spouse □ Parent □ Other_____

SECONDARY DENTAL INSURANCE

Name of Insured_____ SS#_____
Last First MI

Insurance Plan Name and Address: _____

Insurance Phone #_____ Employer Name_____

Insured's DOB_____ ID#_____ Group#_____

Relationship to patient □ Self □ Spouse □ Parent □ Other_____

Responsible Party Information

Name: _____Relationship to patient_____ Male/Female

Address: _____
Street Apartment #

_____
City State Zip Code

SS#_____ DOB_____ DL#_____ State_____

Home#_____Work#_____ Ext._____ Best time to call: _____

Health Information/Medical History Form

HAVE YOU EVER HAD:
☐Hepatitis
☐Liver Disease
☐Epilepsy
☐Seizures
☐Rheumatic Fever
☐Kidney Disease
☐Diabetes
☐Tuberculosis
☐Heart Trouble
☐Damaged Heart Valves
☐Artificial Heart Valves
☐Congenital Heart Lesions
☐Coronary Insufficiency
☐Coronary Occlusion
☐Arteriosclerosis
☐Stroke
☐Cardiac Pacemaker
☐Heart Murmur
☐High Blood Pressure
☐Low Blood Pressure
☐Shortness of Breath
☐Chest Pains
☐Medical Treatment by X-Ray
☐Sexually Transmitted Disease
☐Surgery
☐Glaucoma
☐Prostate Trouble
☐Contact Lenses
☐Drug Reaction
☐Psychiatric Treatment
☐Burning Tongue
☐Ulcer
☐Sinus Problems
☐Asthma
☐Treatment for Tumor/Growth
☐Prosthetic Replacement (Hip, Knee, etc.)
☐Osteoporosis/Osteopenia
☐HIV Positive
☐Sleep Apnea/Obstructive Sleep Apnea

AN UNFAVORABLE REACTION TO A DRUG SUCH AS:
☐Aspirin
☐Barbituates
☐Anesthetics
☐Penicillin
☐Sulfa Drugs
☐Codeine
☐Other_____

HAS A BLOOD MEMBER OF YOUR FAMILY
☐Had Diabetes?
Who_____
At What Age_____

IF FEMALE, ARE YOU NOW:
☐Pregnant
Due Date_____
☐Taking anti-pregnancy Drug
☐Presently in the Menopause
☐Past Menopause

ARE YOU:
☐Presently under the care of a physician
☐Taking any medication now?
List of current Medications
_____
_____
_____
_____
_____
Or within the past year, taking such as:
☐Anticoagulants
☐Cortisone
☐Tranquilizers
☐Nitroglycerin
☐Penicillin
☐Aspirin Daily
☐Digitalis, heart medication
☐Bisphosphonates (for osteoporosis)
Such as: Fosamax, Alendronate
☐Medications for high blood pressure

ARE YOU:
☐Wearing a CPAP Machine
☐Allergic to Dental Anesthetic
☐Aware of recent weight change
☐Subject to frequent urination
☐Often Thirsty
☐Subject to frequent headaches
☐Easily exhausted or fatigued
☐Slow in healing
☐In good health now
☐Aware of grinding or clenching your teeth day or night
☐Satisfied with the appearance of your teeth

HAVE YOU:
☐Ever been told you have gum trouble
☐Ever had trench mouth
☐Ever been treated for Periodontal Disease (Pyorrhea)
☐Ever had orthodontic treatment
☐Had shifting of any teeth

DO YOU:
☐Ever have sore or popping joints
☐Ever have sore teeth
☐Ever notice your ankles swell
☐Have prolonged bleeding after injury or tooth extraction
☐Have a persistent cough or cough up blood
☐Require at least 2 pillows to sleep at night
☐Have any blood disorder
☐Smoke / Have you ever smoked?
☐Use Drugs
☐Use Alcohol

DO YOU:
☐Have unpleasant tastes in your mouth
☐Have bleeding gums
☐Have bad breath
☐Have tooth sensitivity to heat
☐Have tooth sensitivity to cold
☐Have tooth sensitivity to sweets
☐Use dental floss
☐Have any fear of dental treatment

DO YOU HAVE ANY SERIOUS ILLNESS NOT LISTED? If so write it below:
_____
_____
_____

PHYSICIAN'S NAME, ADDRESS, PHONE:
_____
_____
_____

Height: _____
Weight: _____

I CERTIFY THIS TO BE TRUE TO THE BEST OF MY KNOWLEDGE.

PATIENT NAME: (Print)_____

Patient Signature:_____ Date:_____

Doctor Signature:_____