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PATIENT INFORMATION

First Name: ________________________ *MI:* ___ *Last:* ________________ *Preferred:* ___________

Home Phone: ________________ *Work Phone:* _________________ *Cell:* _______________________

Date of Birth: __________________ □ *Male* □ *Female* *SS#:* ___________________________

Email: _____________________________________ *Best Time To Call:* _______________________

Marital Status: □ *Single* □ *Married* □ *Divorced* □ *Separated* □ *Widowed*

Address: ______________________________ *City:* _________________ *State:*___ *Zip:* __________

Emergency Contact: _________________________ *Phone:*_____________ *Relationship:* _________

How did you hear about our office?

□ *Referred by:* _______________________ □ *Insurance* □ *Yelp* □ *Google* □ *Mailing (Postcard)*
□ *Event* □ *Building Promotion* □ *Other* _____________________

INSURANCE INFORMATION

Primary Ins Name: ____________________________ *Phone:* ___________________

Address: ____

ID#: _______________________ *Group#:* ___________________ *Employer:* __________________

Name of Insured: _________________________ *DOB:* _______________ *Relationship:* ___________

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Secondary Ins Name: _____________________________ *Phone:* ___________________

Address: ____

ID#: _______________________ *Group#:* _____________________ *Employer:* _________________

Name of Insured: __________________________ *DOB:* ______________ *Relationship:* ___________
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PATIENT HEALTH HISTORY

	Yes	No
AIDS/HIV Positive	□	□
Alcoholism	□	□
Anemia	□	□
Arthritis	□	□
Asthma	□	□
Blood Disease	□	□
Bone Disease	□	□
Cancer	□	□
Chemical Dependency	□	□
Circulatory Problems	□	□
Convulsions/Seizures	□	□
Diabetes	□	□
Excessive Bleeding	□	□
Epilepsy	□	□
Glaucoma	□	□
Hay Fever	□	□
Head Injuries	□	□
Hearing Impaired	□	□
Heart Disease	□	□
Heart Valve/Murmur	□	□
Hepatitis/Liver Disease	□	□
High Blood Pressure	□	□
Hip/Joint Replacement	□	□

	Yes	No
Kidney Disease	□	□
Lupus	□	□
Low Blood Pressure	□	□
Mitral Valve Prolapse	□	□
Neck & Back Problems	□	□
Nervous Problems/Disorders	□	□
Pacemaker	□	□
Prosthetic/knee Joints	□	□
Psychiatric Care	□	□
Radiation Treatment	□	□
Respiratory Prob/Disorder	□	□
Rheumatic Fever	□	□
Rheumatism	□	□
Scarlet Fever	□	□
Sinus Problems	□	□
Stomach Ulcers	□	□
Stroke	□	□
Thyroid Disease	□	□
Tuberculosis	□	□
Tumors/growths	□	□
Ulcers	□	□
Venereal Disease	□	□

MEDICAL QUESTIONS

Are you under the care of an MD?□ Yes □ No Physician: ______________________ Phone: ________

List any medications you are taking: _________________________

____

____

Have you ever been hospitalized? □ Yes □ No If yes, what was the problem?

____

____

Do you have any disease/problem you think we should know about? □ Yes □ No

____

____

Are you taking or have you ever taken bisphosphonates? □ Yes □ No
*(**Fosamax or Actonel for osteoporosis, chemotherapy, etc**)*

ALLERGIES

Are you allergic to any of the following?

Aspirin □ *Yes* □ *No* *Erythromycin* □ *Yes* □ *No* *Penicillin* □ *Yes* □*No*

Metals □ *Yes* □ *No* *Jewelry* □ *Yes* □*No* *Latex* □ *Yes* □*No*

Codeine □ *Yes* □ *No* *Dental Anesthetics* □ *Yes* □ *No* *Tetracycline* □ *Yes* □*No*

Other Allergies: ____

DENTAL HISTORY

Reason for today's visit? ______________________________ *Date of last dental visit?* __________

Have you ever had oral cancer screening? □ *Yes* □ *No*

Do you snore? □ *Yes* □ *No*

Do you floss your teeth? □ *Yes* □ *No*

Do your gums bleed when you brush? □ *Yes* □ *No*

Do you have problems with bad breath? □ *Yes* □ *No*

Are your teeth sensitive to hot or cold? □ *Yes* □ *No*

Do you smoke or chew tobacco? □ *Yes* □ *No*

Have you or a family member ever been treated for periodontal disease? □ *Yes* □ *No*

Have you ever had complications from extraction? □ *Yes* □ *No*

Have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? □ *Yes* □ *No*

Are you prone to frequent headaches? □ *Yes* □ *No*

Do you grind or clench your teeth? □ *Yes* □ *No*

Have you ever had orthodontic treatment? □ *Yes* □ *No*

If you could change something about your smile what would it be?

□ *whiter teeth* □ *straighter teeth* □ *close space* □ *repair chipped teeth*

□ *replace missing teeth* □ *less gums showing* □ *replace old crowns or caps that don't match*

□ *replace black mercury filling with tooth colored restorations*

For Women Only:

Are you taking birth control pills? □ *Yes* □ *No* *Are you nursing/breastfeeding?* □ *Yes* □ *No*

Are you pregnant? □ *Yes* □ *No* *Expected delivery date:* ______________

Is there a possibility of pregnancy? □ *Yes* □ *No*

NOTE: *Antibiotics (such as Penicillin) may alter the effect of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.*

I certify that I have read and understand the questions above. I will not hold my dentist or any other members of her staff responsible for any errors that I have made in the completion of this form.

Patient: ____ *Date:* ________________

Parent/Guardian: _________________________________ *Date:* ________________