PATIENT INFORMATION

Today's Date_____

Patient Name _____ Birthdate _____

Home Address_____

City _____ State _____ Zip _____ Email_____

Home Phone_____ Cell Phone _____ Work Phone _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Employer _____ Employer Phone _____

Employer Address_____

City _____State _____ Zip _____

Spouse or Parent's Name _____ Birthdate _____

Home Phone_____ Cell Phone _____ Work Phone _____

Spouse or Parent's Employer _____

Employer Address_____

City _____ State _____ Zip _____ Email_____

If patient is a student, name of school/college _____ City _____

Emergency Contact _____ Relation _____ Phone _____

Whom may we thank for referring you? _____

RESPONSIBLE PARTY

Person Responsible for this Account _____ Birthdate _____

Relationship to Patient _____ SS # _____ Email _____

Address_____

City _____ State _____ Zip _____

Home Phone_____ Cell Phone _____ Work Phone _____

Employer _____ Employer Phone _____

Employer Address_____

City _____ State _____ Zip _____

Is this person currently a patient in our office? ☐ Yes ☐ no

DENTAL INSURANCE INFORMATION

Name of Insured _____ Birthdate _____

Relationship to Patient _____ SS # _____ Email _____

Is Insurance Through Employer? ☐ Yes ☐ No

If Yes, Name of Employer _____

Insurance Company _____ Group # _____ Insurance ID # _____

Do you have additional dental insurance? ☐ Yes ☐ No

If yes, complete the following:

Name of Insured _____ Birthdate _____

Relationship to Patient _____ SS # _____ Email _____

Is Insurance Through Employer? ☐ Yes ☐ No

If Yes, Name of Employer _____

Insurance Company _____ Group # _____ Insurance ID # _____

PATIENT INFORMATION

Today's Date_____

Patient Name _____ Birthdate_____

Home Address_____

City _____ State _____ Zip _____ Email_____

Home Phone_____ Cell Phone _____ Work Phone _____

PATIENT MEDICAL / DENTAL HISTORY

Physician _____ Phone _____ Date of last exam _____

	YES	NO
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
3. Are you taking any medications including over the counter medicines and vitamins?	☐	☐

If yes, what are you taking? _____

_____

4. Do you use tobacco?	☐	☐

What type?_____

5. How much alcohol do you consume? _____

	YES	NO
6. Have you had any addictions to alcohol or medications?	☐	☐
7. Are you allergic to or have you had any reactions to any drugs?	☐	☐

If yes, please specify_____

8. Women Only:

A) Are you pregnant or think you may be pregnant?	☐	☐
B) Are you nursing?	☐	☐
C) Are you taking birth control pills?	☐	☐

Please indicate which of the following applies to you. Check only if the answer is yes.

☐ High Blood Pressure	☐ Asthma	☐ Liver Disease	☐ Hepatitis or Jaundice
☐ Low Blood Pressure	☐ Heart Murmur	☐ Cancer	☐ Arthritis
☐ Heart Disease	☐ Joint Replacement / Implant	☐ Rheumatic Fever	☐ Diabetes
☐ Angina	☐ Leukemia	☐ Emphysema	☐ AIDS or HIV Infection
☐ Heart Attack	☐ Swollen Ankles	☐ Cold Sores / Fever Blisters	☐ Fainting / Seizures
☐ Heart Trouble	☐ Epilepsy / Convulsions	☐ Anemia	☐ Frequently Tired
☐ Chest Pains	☐ Easily Winded	☐ Stroke	☐ Hay Fever / Allergies
☐ Cardiac Pacemaker	☐ Tuberculosis	☐ Radiation Therapy	☐ Other _____
☐ Blood Thinners	☐ Respiratory Problems	☐ Bleeding Problems	_____
☐ Kidney Diseases	☐ Sexually Transmitted Diseases	☐ Recent Weight Loss	_____
☐ Stomach Troubles / Ulcers	☐ Thyroid Problem	☐ Glaucoma	_____

COMMENTS

_____

Check only if the answer is yes.

1. Do your gums bleed while brushing or flossing? ☐
2. Have you ever been told that you have gum disease? ☐
3. Have you ever had Root Debridement and Scaling? ☐
4. Have you had gum / bone surgery? ☐
5. Do you feel pain in any of your teeth? ☐
6. Do you have any sores or lumps in or near your mouth? ☐
7. Have you had any head, neck or jaw injuries? ☐
8. Have you ever experienced any of the following problems in your jaw?
   - ☐ Clicking?
   - ☐ Pain (joint, ear, side of face)?
   - ☐ Difficulty in opening or closing?
   - ☐ Difficulty in chewing?
   - ☐ Waking up with headache or jaw tenderness?
9. Do you have frequent headaches? ☐
10. Do you clench or grind your teeth? ☐
11. Do you bite your lips or cheeks frequently? ☐
12. Have you ever had any difficult extractions in the past? ☐
13. Have you had any orthodontic work? ☐
14. Have you ever had prolonged bleeding following extractions? ☐
15. Have you ever had instruction on the correct method of brushing your teeth? ☐
16. Have you ever had instruction on the care of your gums? ☐
17. Are your teeth sensitive to: (Mark all that apply)
    ☐ hot ☐ cold ☐ sweet ☐ sour ☐ liquids / foods?

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

X_____ _____

Signature of Patient, Parent or Guardian Date