

Patient Information (CONFIDENTIAL)

- Male
 Female

Today's Date _____

Home Phone _____

Cell: _____

Email _____

Name _____ Birthdate _____ Soc. Sec # _____

Address _____ City _____ State _____ Zip _____

Check Appropriate Box Minor Single Married Divorced Widowed Separated

Patient's or Parent's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

If Patient is a Student, Name of School / College _____ City _____ State _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

How do you prefer to be contacted? Text Email Cell Home Work Please List _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Driver's License # _____ Birthdate _____ Cell Phone _____

Employer _____ Work Phone _____

Is this Person Currently a Patient in our Office? Yes No Name of Bank _____

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____

Name of Employer _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No

Dental History

Reason for Today's Visit? _____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a check to indicate if you have any of the following:

Bad Breath

Bleeding Gums

Blisters on lips or mouth

Burning sensation on tongue

Chew on one side of mouth

Cigarette pipe or cigar smoking

Clicking or popping jaw

Fingernail biting

Food collection between the teeth

Foreign objects

Grinding teeth

Gums swollen or tender

Jaw pain or tiredness

Lip or cheek biting

Loose teeth or broken fillings

Mouth breathing

Mouth pain, bruising

Orthodontic treatment

Pain around ear

Periodontal treatment

Sensitivity to cold

Sensitivity to heat

Sensitivity to sweets

Sensitivity when biting

Sores or growths in your mouth

How often do you floss? _____

How often do you brush? _____

Health History

Physician _____ Office Phone _____ Date of Last Exam _____

✓ CHECK BOXES IF YOU HAVE ANY OF THE FOLLOWING

AIDS or HIV Infection	<input type="checkbox"/>	Hay Fever / Allergies	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/>
Angina	<input type="checkbox"/>	Date of Attack _____		Rheumatic Fever	<input type="checkbox"/>
Artificial Heart Valves	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	Sexually Transmitted Disease	<input type="checkbox"/>
Back Problems	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>
Bleeding Abnormally	<input type="checkbox"/>	What Type _____		Skin Rash	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	Stomach Troubles / Ulcers	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Stroke	<input type="checkbox"/>
Cardiac Pacemaker	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	Swollen Ankles	<input type="checkbox"/>
Chemical Dependency	<input type="checkbox"/>	Joint Replacement or Implant	<input type="checkbox"/>	Swollen Neck Glands	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	Date of Placement _____		Thyroid Problem	<input type="checkbox"/>
Chest Pains	<input type="checkbox"/>	Kidney Diseases	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>
Circulatory Problems	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	Tumor or growth on head or neck	<input type="checkbox"/>
Cortisone Treatments	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>
Epilepsy / Convulsions	<input type="checkbox"/>	Nervous Problems	<input type="checkbox"/>	Other _____	
Fainting / Seizures	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	_____	
Glaucoma	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	_____	

Are you under medical treatment now? Have you ever been hospitalized for any surgical operation or serious illness?

Do you use tobacco? What kind? _____

Do you use alcohol? Do you use cocaine? Do you use other drugs?

Women:

Are you pregnant? Due Date _____ Are you nursing? Taking birth control pills?

Medications

List any medications you are currently taking and the correlating diagnosis:

Pharmacy Name _____

Phone _____

Do you take asprin daily? YES NO

Allergies

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Local Anesthetics
<input type="checkbox"/> Barbiturates (Sleeping Pills)	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Codeine	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Iodine	<input type="checkbox"/> Other _____
<input type="checkbox"/> Latex	_____

Authorization and Release

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. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of my dependents.

X _____
Signature of patient or parent if minor