Patient Information

Patient Name: ______________________________ Date: __________

Last, First MI (Preferred Name)

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other __________

Social Security #: ______________________ Birth Date: ______________________

Phone (Home): __________ (Work): __________ Ext: ______ Best time to call: __________

Phone (Cell): ______________ E-Mail Address: ______________________________

Address: ____

Street Apartment #

____

City State Zip Code

Employment Information

Employer Name: ______________________ Occupation: ______________________

Address: ____

Street City, State Zip Code Phone

Referral Information

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

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other __________

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

Spouse or Responsible Party Information

Name: ____

☐ Male ☐ Female ☐ Married ☐ Single

Social Security #: ______________________ Birth Date: ______________________

Phone (Home): __________ (Work): __________ Ext: ______ (Cell): __________

Address: ____

Street Apartment #

____

City State Zip Code

Insurance Information

Primary

Name of Insured: ______________________________ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: __________ ID #: __________ Group #: __________

Insured's Address: ____

Street City State Zip Code

Insured's Employer Name: ____

Address: ____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other __________

Insurance Plan Name and Address: ____

____

Secondary

Name of Insured: ______________________________ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: __________ ID #: __________ Group #: __________

Insured's Address: ____

Street City State Zip Code

Insured's Employer Name: ____

Address: ____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other __________

Insurance Plan Name and Address: ____

____

Health Information

Have you ever had any of the following? Please check those that apply:

☐ Abnormal Bleeding
☐ Alcohol/Drug Abuse
☐ Anemia
☐ Anxiety
☐ Arthritis
☐ Artificial Joints/Valves
☐ Asthma
☐ Blood Disease
☐ Blood Transfusion
☐ Cancer
☐ Colitis
☐ Depression
☐ Diabetes
☐ Difficulty Breathing
☐ Dizziness
☐ Emphysema
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Frequent Headaches
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Attack
☐ Heart Disease
☐ Heart Murmur
☐ Hemophilia
☐ Hepatitis
☐ Herpes/Fever Blisters
☐ High Blood Pressure
☐ High Cholesterol
☐ HIV+/AIDS
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Low Blood Pressure
☐ Lupus
☐ Mental Disorders
☐ Mitral Valve Prolapse
☐ Nervous Disorders
☐ Pacemaker
☐ Pre-Medicate
☐ Psychiatric Problems
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Seizures
☐ Shingles
☐ Sickle Cell Disease
☐ Sinus Problems
☐ Sleep Apnea
☐ Stomach Problems
☐ Stroke
☐ Thyroid Problems
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease

• Please list any medical allergies:____

Latex Allergy Yes☐ No☐ Metal Allergy Yes☐ No☐

• Please list any prescription, over-the-counter or herbal supplement drugs that you are taking:______________________
____

• Please list any medical condition(s) that you have ever had:____________________________________
____

• Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain: ____

• Name of Physician: ______________________ Phone:______________________

• Do you smoke or use tobacco in any form? Yes☐ No☐
• Have you ever taken Fosamax, or any other bisphosphonate? Yes☐ No☐
• Have you ever taken Phen-fen? Yes☐ No☐
• **For women**: Are you using a prescribed method of birth control? Yes☐ No☐
Are you pregnant? Yes☐ No☐
Are you nursing? Yes☐ No☐

Dental History

Date of Last Dental Visit: ______________ Reason for this visit: ______________________

• Has your doctor told you that you require antibiotics before dental treatment? Yes☐ No☐
• Are you currently in pain? Yes☐ No☐
• Have you ever had a serious problem associated with any previous dental work? Yes☐ No☐
• Have you ever experienced pain/discomfort in your jaw joint? Yes☐ No☐
• How many times a week do you brush?_______ Floss? ______
• Do you currently have night guard? ________Upper or lower?__________

To the best of my knowledge, all of the preceding answers and information provided are true and correct. I understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

______________________________________ Date: ______________________
Signature of patient, parent or guardian