Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: ____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell Phone or Pager: _____

Address: _____
Street Apartment # E-MAIL ADDRESS

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

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

MEDICAL HISTORY

☐ Allergies _____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer

☐ Chemotherapy

_____
☐ Diabetes
☐ Dizziness / Fainting
☐ Epilepsy
☐ Excessive Bleeding
☐ Glaucoma
☐ Growths / Tumors
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur / Mitral Valve Prolapse
☐ Artificial Heart Valve
☐ Hepatitis / Jaundice
☐ High Blood Pressure
☐ HIV or AIDS
☐ Kidney Disease
☐ Latex Allergy
☐ Liver Disease
☐ Mental Health Issues
☐ Osteoporosis
☐ Pacemaker
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sexually Transmitted Disease
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Thyroid Problems
☐ Tuberculosis
☐ Ulcers
☐ Other

DRUG ALLERGIES

☐ Codeine Allergy
☐ Penicillin Allergy
Other:_____
_

WOMEN

☐ Are you pregnant?
Due Date:_____
☐ Are you nursing?

DENTAL HISTORY

☐ Bad Breath
☐ Bite/ Chew Nails
☐ Biteguard Therapy
☐ Bleeding Gums
☐ Bleaching Treatment
☐ Blisters/ Sores on Lips
☐ Burning sensation on tongue
☐ Chew on one side of mouth
☐ Cigarette, pipe, or cigar smoking
☐ Clench/ Grind Teeth
☐ Gums swollen or tender
☐ Jaw Pain or tiredness
☐ Loose teeth or broken fillings
☐ Mouth Breathing
☐ Mouth pain, brushing
☐ Orthodontic treatment
☐ Pain around ear
☐ Periodontal treatment
☐ Sensitivity to cold, heat or sweets
☐ Wisdom teeth removed

How often do you floss?
_____

How often do you brush?
_____
_

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Please list all physicians participating in your health care _____
  _____Phone:_____
- Please list all medications or herbs_____ _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative
☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Website

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

_

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell Phone or Pager: _____

Address: _____

Street Apartment #

_____

City State Zip Code **E-MAIL ADDRESS**

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____

Street City, State Zip Code Phone

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 ☐ Other _____

Insurance Plan Name and Address: _____

_____

Insurance Plan Phone Number: _____

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 ☐ Other _____

Insurance Plan Name and Address: _____

_____

Consent for Services

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. If there is any change in my medical status, I will inform the dentist. I understand that this information will be used by my dentist to help determine appropriate and healthful dental treatment. I grant my permission to you or your assignee to telephone me at home or at my work to discuss matters related to this form. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to me during the period of such care to third party payers and/ or other health practitioners.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, or guardian

☐