Patient Information

Date_____ ☐Male ☐Female ☐Married ☐Single ☐Divorced ☐ Student ☐Child

Last Name_____ First Name_____ Middle_____

Date of Birth_____ Social Security Number_____

Address _____ City _____ State _____ Zip _____

E-Mail _____ Home #_____

Work #_____ Cell # _____

Employer _____ Phone # _____

If patient is a minor, give parents or guardian's name_____

Name of nearest relative not living with you_____

Complete Address_____ Phone # _____

Whom may we thank for referring you to our office? ☐Patient _____

☐Mailing to Home (List Publication) _____ ☐Location ☐Yellow Pages ☐Other_____

Responsible Party Information

Last Name_____ First Name_____ Middle_____

Date of Birth _____Social Security #_____ Relationship to Patient_____

Address _____ City _____ State _____ Zip _____

Home #_____ Work #_____ Cell # _____

Previous Address (if less than 3 yrs.)_____

Employer_____ Occupation _____ No. Years Employed _____

Address_____ Phone # _____

Spouse Information

Last Name_____ First Name_____ Middle_____

Date of Birth _____Social Security #_____ Relationship to Patient_____

Address _____ City _____ State _____ Zip _____

Home #_____ Work #_____ Cell # _____

Employer_____ Occupation _____ No. Years Employed _____

Address_____ Phone # _____

Dental Insurance Information

Primary Dental Insurance	Secondary Dental Insurance
Insured's Name_____	Insured's Name_____
Insured's Date of Birth_____	Insured's Date of Birth_____
Insured's Phone #_____	Insured's Phone #_____
Insured's Social Security #_____	Insured's Social Security #_____
Insurance Company _____	Insurance Company _____
Company Address _____	Company Address _____
_____	_____
Insurance Company Phone # _____	Insurance Company Phone # _____
Insured's Employer _____	Insured's Employer _____

Dental Information

Do your gums bleed when you brush? ☐ Yes ☐No

Are your teeth sensitive to heat or cold? ☐ Yes ☐No

Are your teeth sensitive to Pressure? ☐ Yes ☐No

Do you have a fear of the dentist? ☐ Yes ☐No

Do you grind or clench your teeth? ☐ Yes ☐No

Have you had your teeth bleached before? ☐ Yes ☐No

How do you feel about the appearance of your teeth? Do you: ☐Love them ☐Accept them ☐Want to change them

How do you feel about the appearance of your smile? Do you: ☐Love it ☐Accept it ☐Want to change it

Date of Last Examination _____ What was done at that time?_____

Are you interested in using Nitrous Oxide (Laughing Gas) ..... ☐Yes ☐No

Medical History Information

Patient Name _____

1. Describe your current dental problem(s)?_____

_____

2. Are you having pain or discomfort at this time? ☐Yes ☐No
3. Have you been a patient in the hospital during the past two years? ☐Yes ☐No
4. Have you been under the care of a medical doctor during the past two years? ☐Yes ☐No

   Physician's Name_____ Phone Number _____

   Address_____
5. Have you taken any medication or drugs in the past two years? ☐Yes ☐No
6. **Are you now taking any medications or drugs? (includes medication for pain, recreational drugs, and hormones)** ☐Yes ☐No

   If yes, please list:_____
7. **Are you currently taking any type of Herbal Supplements?** ☐Yes ☐No

   If yes, please list:_____
8. **Are you sensitive or allergic to any medication or anesthetics?** ☐Yes ☐No

   If yes, please list:_____
9. Have you ever taken the diet drug Phen-Phen? ☐Yes ☐No
10. Indicate which of the following you have had or have at the present. Check "yes" or "no" for each item.

Heart Failure	☐Yes ☐No	*Artificial Joints (hip, knee, etc.)	☐Yes ☐No	Hepatitis B (serum)	☐Yes ☐No
Heart Disease or Attack	☐Yes ☐No	Kidney Trouble	☐Yes ☐No	Hepatitis C	☐Yes ☐No
Angina Pectoris	☐Yes ☐No	Ulcers	☐Yes ☐No	Venereal Disease	☐Yes ☐No
Congenital Heart Disease	☐Yes ☐No	Diabetes	☐Yes ☐No	A.I.D.S.	☐Yes ☐No
*Heart Murmur	☐Yes ☐No	Thyroid Problems	☐Yes ☐No	H.I.V. Positive	☐Yes ☐No
High Blood Pressure	☐Yes ☐No	Glaucoma	☐Yes ☐No	Cold Sores/Fever Blisters	☐Yes ☐No
Arteriosclerosis	☐Yes ☐No	Cancer	☐Yes ☐No	Hemophilia	☐Yes ☐No
*Mitral Valve Prolapse	☐Yes ☐No	Emphysema	☐Yes ☐No	Anemia	☐Yes ☐No
Artificial Heart Valve	☐Yes ☐No	Chronic Cough	☐Yes ☐No	Sickle Cell Disease	☐Yes ☐No
*Heart Pacemaker	☐Yes ☐No	Tuberculosis	☐Yes ☐No	Bruise Easily	☐Yes ☐No
Heart Surgery	☐Yes ☐No	Asthma	☐Yes ☐No	Liver Disease	☐Yes ☐No
*Rheumatic Fever	☐Yes ☐No	Seasonal Allergies	☐Yes ☐No	Yellow Jaundice	☐Yes ☐No
Arthritis	☐Yes ☐No	Allergies or Hives	☐Yes ☐No	Epilepsy or Seizures	☐Yes ☐No
Rheumatism	☐Yes ☐No	Sinus Trouble	☐Yes ☐No	Fainting or Dizzy Spells	☐Yes ☐No
Cortisone Medicine	☐Yes ☐No	Radiation Therapy	☐Yes ☐No	Nervousness	☐Yes ☐No
Drug Addiction	☐Yes ☐No	Chemotherapy	☐Yes ☐No	Tumors	☐Yes ☐No
Stroke	☐Yes ☐No	Hepatitis A (infectious)	☐Yes ☐No	Developmentally Disabled	☐Yes ☐No
Low Blood Pressure	☐Yes ☐No	Breathing Problems	☐Yes ☐No	Frequent Diarrhea	☐Yes ☐No
Blood Disease	☐Yes ☐No	Shortness of Breath	☐Yes ☐No	Excessive Thirst	☐Yes ☐No
Hypoglycemia	☐Yes ☐No	Pain in Jaw Joints	☐Yes ☐No	Alzheimer's Disease	☐Yes ☐No

11. Do your ankles swell during the day? ☐Yes ☐No
12. Have you lost or gained more than 10 pounds in the past year? ☐Yes ☐No
13. Are you on a special diet? ☐Yes ☐No
14. Do you have or have you had any disease, condition, or problem not listed? ☐Yes ☐No

    If yes, please list:_____
15. Do you use tobacco products? ☐Yes ☐No
16. Do you use alcohol products? ☐Yes ☐No

FOR WOMEN ONLY:

17. Are you pregnant? ☐Yes ☐No If yes, what month?_____ Are you nursing? ☐Yes ☐No
18. Are you taking birth control pills? ☐Yes ☐No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

PATIENT SIGNATURE_____ **DATE**_____

PARENT OR RESPONSIBLE PARTY _____ **RELATIONSHIP TO PATIENT** _____

Medical Review: Reviewed by:_____ Date_____
Reviewed by:_____ Date_____
Reviewed by:_____ Date_____
Reviewed by:_____ Date_____
Reviewed by:_____ Date_____
Reviewed by:_____ Date_____

Medical History Update by Patient: Initials_____ Date_____
Initials_____ Date_____
Initials_____ Date_____
Initials_____ Date_____
Initials_____ Date_____
Initials_____ Date_____