

Patient Information

Name: _____ Preferred Name: _____

Home Address: _____ City: _____ State _____ Zip: _____

Home #: _____ Work #: _____ Mobile #: _____

Email: _____

Sex: M / F Birth Date: ____ / ____ / ____ SS#: _____

Family Status (circle): Single Married Divorced Child Spouse's Name: _____

How did you first hear about our office? (circle one):

- | | | | |
|-----------------|-----------------------|--------------|-------------------|
| Another Patient | Another Dental Office | Brochure | Online Search |
| Facebook | Work | School | Insurance Website |
| Sign -Drive by | Walk in | Other: _____ | |

Whom may we thank for referring you to our practice? _____

Person Responsible for Account

Name of responsible party: _____

Relationship to patient (Circle): Self Spouse Parent Other: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ Mobile #: _____

Email: _____

Birth Date: ____ / ____ / ____ SS#: _____

Contact Information

What is the best way to communicate with you? Home Phone / Mobile Phone/ Text / Email

In the event of an emergency, whom should we contact? Name _____

Relationship _____ Home #: _____ Work #: _____ Mobile #: _____

Insurance Information (Primary)

Name of Insured: _____ Relationship to patient: _____

Insured Birth Date: ___ / ___ / _____

Insurance Plan Name: _____ Insurance Co Phone #: _____

Claims Address _____

City, State, Zip _____

Group #: _____ ID #: _____

Insurance Information (Secondary)

Name of Insured: _____ Relationship to patient: _____

Insured Birth Date: ___ / ___ / _____

Insurance Plan Name: _____ Insurance Co Phone #: _____

Claims Address _____

City, State, Zip _____

Group #: _____ ID #: _____

Employment Information

Employer Name: _____ Phone: _____

Address: _____

City, State, Zip: _____

Medical History

Patient Name: _____ Date of Birth: _____

1. Date of last physical exam: _____ Physician's Name: _____

Physician's Phone#: _____

2. Have you ever been hospitalized (if yes, explain below)? Yes No

3. Have you been under the care of a medical doctor during the past two years? Yes No
If yes, what for? _____

4. Have you ever had any excessive bleeding requiring special treatment? Yes No

5. **Women:** Are you pregnant/trying to get pregnant/breast feeding? Yes No

6. Are you allergic to or have you had an allergic reaction to any of the following (please circle if yes):

Local Anesthetic Penicillin Codeine Other Antibiotic: _____

Latex Acrylic Metals Other: _____

7. Are you taking or have you ever taken any of the following medications (please circle if yes):

Fosamax Actonel Boniva For how long? _____

Aredia Reclast Zometa When did you stop? _____

8. Please list other medications you are taking:

Have you ever had any of the following?

Chest Pains	Yes No	Shortness of Breath	Yes No	Hives/Skin Rashes	Yes No
Heart Failure	Yes No	Ulcers	Yes No	Alcoholism	Yes No
Heart Disease	Yes No	Mental Health Issues	Yes No	Herpes	Yes No
Heart Attack	Yes No	Emphysema	Yes No	Glaucoma	Yes No
Heart Problems	Yes No	Fainting/Dizziness	Yes No	Steroid Treatment	Yes No
Angina Pectoris	Yes No	Eating Disorder	Yes No	Arthritis	Yes No
Heart Surgery	Yes No	Epilepsy/Seizures	Yes No	Dental Implant	Yes No
Liver Disease	Yes No	Persistent Cough	Yes No	Dentures/Partials	Yes No
Hypertension	Yes No	Tuberculosis	Yes No	Birth Defects	Yes No
Heart Murmur	Yes No	Asthma	Yes No	HIV+, AIDS, ARC	Yes No
Rheumatic Fever	Yes No	Hepatitis A	Yes No	Hay Fever	Yes No
Sickle cell disease	Yes No	Hepatitis C or D	Yes No	Bruise easily	Yes No
Sinus Trouble	Yes No	Pacemaker	Yes No	Jaundice	Yes No
Artificial Joints	Yes No	Night Sweats	Yes No	Kidney Trouble	Yes No
Thyroid Disease	Yes No	Stroke	Yes No	Diabetes	Yes No
Anaemia	Yes No	Drug Addiction	Yes No	Chemotherapy	Yes No
Blood Transfusion	Yes No	Cold Sores	Yes No	Cancer	Yes No
Mitral Valve Prolapse (MVP)	Yes No	Radiation Therapy	Yes No	Transplant	Yes No

Patient Signature: _____ Date _____

Dental History

1. Date of last dental exam: _____ Date of last dental x-rays: _____

2. Previous dentist's name / location: _____

3. Are you having tooth or gum pain at this time? Yes No

4. Do you feel nervous about having dental treatment? Yes No

5. Have you ever had a bad experience in a dental office? Yes No

6. Do your gums bleed when brushing / flossing? Yes No

7. Have you ever seen a periodontist? Yes No

8. Have you ever had a "deep cleaning" (Scaling and Root Planing)? Yes No

9. Is there anything you would like to speak with the Doctor about in private? Yes No

10. Would you be interested in discussing ways to improve your smile? Yes No

If yes, please explain: _____

Do you have any of the following dental concerns:

Clicking in jaw joint Yes No Sensitivity to: Hot Cold Sweets Biting

Pain in or around your ears Yes No Swelling Bleeding Gums

Difficulty opening or closing Yes No Bad Taste Bad Breath

Difficulty chewing Yes No Food Catching Tooth Pain

History of trauma to jaw or face Yes No Clenching Grinding

Diagnosis of TMJ/TMD Yes No Other: _____

To the best of my knowledge, the information above is complete and accurate.

Signature: _____ Date _____