Patient Information

Name: _____ Preferred Name: _____

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

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

Email: _____

Sex: Birth Date: SS#:_____

Family Status (circle): 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): 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

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)?
_____
3. Have you been under the care of a medical doctor during the past two years?
If yes, what for? _____
4. Have you ever had any excessive bleeding requiring special treatment?
5. Women: Are you pregnant/trying to get pregnant/breast feeding?

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	Shortness of Breath	Hives/Skin Rashes
Heart Failure	Ulcers	Alcoholism
Heart Disease	Mental Health Issues	Herpes
Heart Attack	Emphysema	Glaucoma
Heart Problems	Fainting/Dizziness	Steroid Treatment
Angina Pectoris	Eating Disorder	Arthritis
Heart Surgery	Epilepsy/Seizures	Dental Implant
Liver Disease	Persistent Cough	Dentures/Partials
Hypertension	Tuberculosis	Birth Defects
Heart Murmur	Asthma	HIV+, AIDS, ARC
Rheumatic Fever	Hepatitis A	Hay Fever
Sickle cell disease	Hepatitis C or D	Bruise easily
Sinus Trouble	Pacemaker	Jaundice
Artifical Joints	Night Sweats	Kidney Trouble
Thyroid Disease	Stroke	Diabetes
Anaemia	Drug Addiction	Chemotherapy
Blood Transfusion	Cold Sores	Cancer
Mitral Valve Prolapse (MVP)	Radiation Therapy	Transplant

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?
4. Do you feel nervous about having dental treatment?
5. Have you ever had a bad experience in a dental office?
6. Do your gums bleed when brushing / flossing?
7. Have you ever seen a periodontist?
8. Have you ever had a "deep cleaning" (Scaling and Root Planing)?
9. Is there anything you would like to speak with the Doctor about in private?
10. Would you be interested in discussing ways to improve your smile?

If yes, please explain: _____

Do you have any of the following dental concerns:

Clicking in jaw joint	Sensitivity to: ☐ Hot ☐ Cold ☐ Sweets Biting
Pain in or around your ears	☐ Swelling ☐ Bleeding Gums
Difficulty opening or closing	☐ Bad Taste ☐ Bad Breath
Difficulty chewing	☐ Food Catching ☐ Tooth Pain
History of trauma to jaw or face	☐ Clenching ☐ Grinding
Diagnosis of TMJ/TMD	Other: _____

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

Signature: _____ Date_____