



Patients First Name _____ MI _____ Last Name _____

ABOUT YOU

Female Male

Today's date _____

E-mail address _____

I prefer to be called _____

Birth date _____ Age _____ SS# _____

Address _____ Apt # _____

City _____ State _____ Zip _____

Phone-Home _____ Cell _____

Work phone _____ Ext.# _____

Employer _____

Address _____

Occupation _____

Where and when best times to reach you? _____

Referred by _____

Other family members seen by us _____

Previous dentist _____

Last visit date _____

ABOUT SPOUSE

Name-First _____ Last _____

Birth date _____ Age _____ SS# _____

Phone-Home _____ Cell _____

Phone-Work _____ Ext.# _____

Employer _____

WHO IS RESPONSIBLE FOR YOUR ACCOUNT

Name-First _____ Last _____

Relation _____

SS# _____ Driver's license # _____

Work phone _____ Ext.# _____

Cell phone _____

Employer _____

WHO SHOULD WE CONTACT IN AN EMERGENCY?

Name-First _____ Last _____

Relationship _____

Phone-Home _____ Cell _____

PRIMARY INSURANCE COVERAGE

Dental coverage? Yes No

Insurance name _____

Insurance address _____

Insurance phone _____

Group #, plan, local or policy # _____

Insureds name _____

Insureds relation to patient _____

Insureds birth date _____

Insureds subscriber ID _____

Insureds employer _____

SECONDARY INSURANCE COVERAGE

Dental coverage? Yes No

Insurance name _____

Insurance address _____

Insurance phone _____

Group #, plan, local or policy # _____

Insureds name _____

Insureds relation to patient _____

Insureds birth date _____

Insureds subscriber ID _____

Insureds employer _____

YOUR MEDICAL CARE

Do you have a personal physician?

Yes No

Physician's name _____

Physician's phone _____

Date of last visit _____

Are you currently under the care of a physician? Yes No

If yes, please explain _____

Your current physical health is:

Good Fair Poor





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WHY HAVE YOU COME TO THE DENTIST TODAY?

List reasons here: _____

HEALTH INFORMATION

Have you ever taken Fosamax, Actonel, Boniva, or any other biphosphonate? Yes No

Do you take prescription, over-the-counter, or herbal supplement drugs? Yes No

If YES, list each one: _____

FOR WOMEN

Yes No Are you using a prescribed birth control method?

Yes No Are you pregnant?

Yes No Are you nursing?

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

- Yes No Abnormal Bleeding
- Yes No Alcohol/Drug Abuse
- Yes No Anemia
- Yes No Arthritis
- Yes No Artificial Bones, Joints, Valves
- Yes No Asthma
- Yes No Blood Transfusion
- Yes No Cancer, Chemotherapy
- Yes No Colitis
- Yes No Congenital Heart Defect
- Yes No Diabetes
- Yes No Difficulty Breathing
- Yes No Emphysema
- Yes No Epilepsy
- Yes No Fainting Spells
- Yes No Frequent Headaches
- Yes No Glaucoma
- Yes No Hay Fever
- Yes No Heart Attack
- Yes No Heart Murmur
- Yes No Heart Surgery
- Yes No Hemophilia
- Yes No Hepatitis
- Yes No Herpes, Fever Blisters

- Yes No High Blood Pressure
- Yes No HIV positive, AIDS
- Yes No Hospitalized for Any Reason
- Yes No Kidney Problems
- Yes No Liver Disease
- Yes No Low Blood Pressure
- Yes No Mitral Valve Prolapse
- Yes No Pacemaker
- Yes No Psychiatric Problems
- Yes No Radiation Treatments
- Yes No Rheumatic / Scarlet Fever
- Yes No Seizures
- Yes No Shingles
- Yes No Sickle Cell Disease / Traits
- Yes No Sinus Problems
- Yes No Stroke
- Yes No Thyroid Problems
- Yes No Tuberculosis (TB)
- Yes No Ulcers
- Yes No Venereal Disease

List any other serious medical conditions that you have ever had: _____





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SLEEP

- Yes No Do you snore while sleeping
- Yes No Have you been diagnosed/treated for sleep apnea?
- Yes No Do you use a CPAP or other appliance?

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

- | | |
|---|---|
| <input type="radio"/> Yes <input type="radio"/> No Aspirin | <input type="radio"/> Yes <input type="radio"/> No Jewelry |
| <input type="radio"/> Yes <input type="radio"/> No Codeine | <input type="radio"/> Yes <input type="radio"/> No Latex |
| <input type="radio"/> Yes <input type="radio"/> No Dental Anesthetics | <input type="radio"/> Yes <input type="radio"/> No Metals |
| <input type="radio"/> Yes <input type="radio"/> No Erythromycin | <input type="radio"/> Yes <input type="radio"/> No Penicillin |
| | <input type="radio"/> Yes <input type="radio"/> No Tetracycline |

List any other drugs or materials that you are allergic to: _____

- | | |
|---|--|
| <input type="radio"/> Yes <input type="radio"/> No Have you ever had a serious or difficult problem associated with previous dental work? | How many times a week do you floss?
_____ |
| <input type="radio"/> Yes <input type="radio"/> No Do you require antibiotics before dental treatment? | How many times a day do you brush?
_____ |
| <input type="radio"/> Yes <input type="radio"/> No Are you currently in pain? | What type of tooth brush bristles:
<input type="radio"/> Soft <input type="radio"/> Medium <input type="radio"/> Hard |
| <input type="radio"/> Yes <input type="radio"/> No Do your gums ever bleed? | Your current dental health is:
<input type="radio"/> Good <input type="radio"/> Fair <input type="radio"/> Poor |
| <input type="radio"/> Yes <input type="radio"/> No Do you like your smile? | |
| <input type="radio"/> Yes <input type="radio"/> No Would you like whiter teeth? | |
| <input type="radio"/> Yes <input type="radio"/> No Fresher Breath? | |
| <input type="radio"/> Yes <input type="radio"/> No Have you ever had pain or discomfort in your jaw joint? | |
| <input type="radio"/> Yes <input type="radio"/> No Do you smoke or use tobacco? | |

Additional comments: _____

CONSENT

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest 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.

Payment is due at time of service unless prior arrangements have been made. I understand that I am responsible for payment of services rendered and also responsible of any copay and deductibles that my insurance does not cover.

Signature _____ Date _____

