Date: _____

Patient's Last Name_____ First Name _____ (MI)_____

Home Address_____
Street CITY STATE ZIP CODE

Patient's SS#_____-_____-_____

Birth date _____ Age_____

Preferred name (**nickname**)_____

Home Phone_____ Cell_____

Drivers License #_____

Email Address_____

Occupation_____

Employer_____

Work Address_____

_____

Work Phone_____

Spouse's name_____

DENTAL INSURANCE

Has your dental insurance changed? Yes? No?
If yes, please provide us with the following information:

Insurance Co.
#1_____

Group#_____

Do you have other dental insurance coverage? Yes? No?
Other Insurance Co.
#2_____

Group#_____

Insured's Name_____

Insured's Date of Birth _____

Insured's Person's SS# _____--_____--_____

Insured's Occupation_____

Insured's Employer_____

Address_____

_____

Phone Number _____

This coverage is through Self? Spouse? Parent? Other?

Who referred you to our office?

_____

Patients' regular physicians:

_____

Your current health is? Good? Fair? Poor?

Do you smoke or use tobacco? Yes? No?

Do you use marijuana (Cannabis)? Yes? No?

If yes, for what purpose: Medical/ Recreational/ Both

Are you presently taking any prescription drugs? Yes? No?
If yes, please list:_____

Do you HAVE/HAD any of the following Medical problems?

Y N	Heart Attack/Stroke	Y N	Hepatitis A, B, C
Y N	HIV +/Aids	Y N	Cancer/Chemotherapy
Y N	Shingles	Y N	Heart Surgery/Pacemaker
Y N	Kidney Problems	Y N	Anemia
Y N	Sinus Problems	Y N	(High) (Low) Blood Pressure
Y N	Endocarditis	Y N	Severe Headaches
Y N	Diabetes	Y N	Psychiatric Problems/Anxiety
Y N	Drug/Alcohol Abuse	Y N	Tuberculosis (TB)
Y N	Respiratory Problems	Y N	Sickle Cell Disease
Y N	Joint Replacement	Y N	Epilepsy/Seizures/Fainting
Y N	Hemophilia	Y N	Rheumatic Fever
Y N	Heart Murmur	Y N	Mitral Valve Prolapse
Y N	Esophagitis/Reflux	Y N	Thyroid Problems
Y N	Artificial Heart Valve	Y N	Congenital Heart Defect

List any serious medical conditions since your last visit.

_____

Have you ever been pre-medicated prior to a dental appointment? Y N

Are you allergic to any of the following?

Y N	Penicillin	Y N	Dental Anesthetics
Y N	Erythromycin	Y N	Aspirin
Y N	Codeine	Y N	Latex

Are you allergic to any other drugs? If yes, please list:

_____

_____

For women, are currently pregnant? Yes? No?

DENTAL HISTORY

Why have you come to the dentist today?

_____

_____

Are you currently in pain? Yes? No?

Are you under any stress or anxiety at home or work? Yes No

Do you experience stress when you visit a dental office? Yes No

The approximate date of your last visit? _____

Have you ever experienced TMJ problems? Yes No
(TMJ is pain or discomfort in your jaw) joints)

Your current dental health is? Good? Fair? Poor?

Do you grind your teeth? Yes No

Do you like your smile? Yes No

Do your gums ever bleed? Yes No

Would you like to prevent dentures? Yes No

It is the patient/insured responsibility to notify our office of any insurance changes