



**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: \_\_\_\_\_

- Yes  No Have you ever had a serious or difficult problem associated with previous dental work?
- Yes  No Do you require antibiotics before dental treatment?
- Yes  No Are you currently in pain?
- Yes  No Do your gums ever bleed?
- Yes  No Do you like your smile?
- Yes  No Would you like whiter teeth?
- Yes  No Fresher Breath?
- Yes  No Have you ever had pain or discomfort in your jaw joint?
- Yes  No Do you smoke or use tobacco?

How many times a week do you floss? \_\_\_\_\_

How many times a day do you brush? \_\_\_\_\_

What type of tooth brush bristles:

- Soft  Medium  Hard

Your current dental health is:

- Good  Fair  Poor

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 \_\_\_\_\_

