Date____________ **Confidential Responsible Party Information** A B C

Name____________________ Marital Status________
Last First Middle

Residence____________________ ☐ Own ☐ Rent
Street City State Zip

Mailing Address____________________
Street City State Zip

How long at this address__________ Home Phone__________ Work Phone__________

Previous Address (if less than 3 yrs.)____________________
Street City State Zip

Social Security #__________ Birthdate__________ Relationship to Patient__________

Employer__________ Occupation__________ No. Years Employed__________

Spouse's Name____________________ Relationship to Patient__________
Last First Middle

Employer__________ Occupation__________ No. Years Employed__________

Social Security #__________ Birthdate__________ Work Phone__________

Confidential Patient Information

Patient's Name____________________
Last First Middle

Address____________________
Street City State Zip

Home Phone__________ Birthdate__________ Social Security #__________

If patient is a minor, give parent's or guardian's name__________

Whom may we thank for referring you to our office?__________

Insurance Information

Policy Holder's Name____________________ and Soc.Sec. #__________

Insurance Company__________ Group No.__________ Union Local No.__________

Insurance Co. Address____________________ Insurance Co. Phone__________

Policy Holder's Employer____________________

Do you have dual coverage? No ☐ Yes ☐ If yes:

Policy Holder's Name____________________ and Soc. Sec. #__________

Insurance Company__________ Group No.__________ Union Local No.__________

Insurance Co. Address____________________ Insurance Co. Phone__________

Policy Holder's Employer____________________

Emergency Information

Name of nearest relative not living with you____________________

Complete Address____________________

Phone__________ Relationship:__________

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor)____________________

Updates (date & initial)____________________

CONFIDENTIAL (for record and pretreatment evaluation)
© Zuelke & Associates, Inc. 0601

Patient Name: ______________________ Patient Date of Birth: ______________________

Who may we thank for referring you to our office? ______________________________

DENTAL HISTORY

Question	
Are you apprehensive about dental treatment?	Y N
Does your jaw make noise so that it bothers you or others?	Y N
Do you wear complete or partial dentures?	Y N
Do you have difficulty in chewing your food?	Y N
Do you clench or grind your jaws frequently?	Y N
Have you ever noticed slow healing sores in/about your mouth?	Y N
Are you aware of an uncomfortable bite?	Y N
Do you have pain in the face, cheeks, jaws, joints, throat or temples?	Y N
How often do you brush? ______________	Y N
How often do you floss? ______________	
Do you take fluoride supplements?	
Have you had a blow to the jaw (trauma)?	Y N
Do you have a temporomandibular (jaw) disorder (TMD)?	Y N
Are you dissatisfied with the appearance of your teeth?	Y N
Do you gag easily?	Y N
Do you currently have dental pain that is keeping you up at night?	Y N
Do you feel pain when your teeth come into Contact with:	
Hot foods or liquids?	Y N
Cold foods or liquids?	Y N
Sours or sweets?	Y N

Are you allergic or have you reacted adversely, to any of the following? (Please circle applicable)

Local anesthetics ("Novocaine")
Latex or rubber dam
Barbituates, sedatives or sleeping pills
Aspirin, Acetaminophen or Ibuprophen
Codeine, Demerol or other narcotics
Penicillin or other antibiotics
Reaction to metals
Sulfa drug
Other (please list):______________________

During the past 12 months, have you taken:

Antibiotics or Sulfa drugs?	Y N	Cortisone (steroids)?	Y N
Fosamax or any other bisphosphonate?	Y N	Aspirin?	Y N
Anticoagulants (e.g., Coumadin)?	Y N	Natural remedies?	Y N
Digitalis or drugs for heart trouble?	Y N	Insulin, Orinase or similar drug?	Y N
High blood pressure medicine?	Y N	Tranquilizers?	Y N
Nitroglycerin?	Y N		

MEDICAL HEALTH HISTORY

Patient Name: ______________________ Date of Birth: _______________ Current Physician: _____________________

Physician's Phone #: _________________ Date of last visit: ______________________

Your impression of your current health? [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Do you have, or have you had, any of the following?

Heart Problems	Y	N
Chest Pain	Y	N
Shortness of breath	Y	N
Blood pressure problems	Y	N
Heart murmur	Y	N
Heart Valve Problem	Y	N
Taking Heart medication	Y	N
Rheumatic fever	Y	N
Pacemaker	Y	N
Artificial Heart valve	Y	N

Blood Problems	Y	N
Easy Bruising	Y	N
Frequent nosebleeds	Y	N
Abnormal Bleeding	Y	N
Blood disease (anemia)	Y	N
Ever require a blood transfusion	Y	N

Allergy Problems	Y	N
Hay Fever	Y	N
Sinus problems	Y	N
Skin rashes	Y	N
Taking allergy medication	Y	N

Do you use Tobacco? Y N
If so, how much? ________________

Do you have any disease, condition or problem not listed previously that you feel we should know about? Y N
If so, please describe:

____

____

WOMEN

Are you taking contraceptives/other hormones?	Y	N
Are you pregnant?	Y	N
Expected due date: _______________		
Are you nursing?	Y	N
Have you reached menopause?	Y	N
If no, do you have any symptoms?	Y	N

Intestinal Problems	Y	N
Ulcers	Y	N
Weight gain or loss	Y	N
Special diet	Y	N
Constipation/Diarrhea	Y	N
Kidney or Bladder problems	Y	N

Bone or Joint problems	Y	N
Arthritis	Y	N
Back or neck pain	Y	N
Joint replacement, date: _____________	Y	N

Diabetes	Y	N
Uriniate more than 6 times a day	Y	N
Thirsty or mouth is dry much of the time	Y	N
Family history of Diabetes	Y	N

Fainting Spells, Seizures, Epilepsy or	Y	N
other neurological disease	Y	N
Stroke(s)	Y	N
Frequent or severe headaches	Y	N
Thyroid Problems	Y	N
Persistent cough or swollen glands	Y	N
Cancer/Tumor	Y	N
Tuberculosis or other respiratory disease	Y	N
Hepatitis, Jaundice or Liver trouble	Y	N
Herpes or other STI	Y	N
HIV Positive/AIDS	Y	N
Glaucoma	Y	N
History of head injury	Y	N
History of drug or alcohol abuse	Y	N

Please list all medications, Vitamins and supplements, with dosages, that you are currently taking or have taken within the past 12 months (use back of page if necessary).

____

____

____

____

Patient/Parent signature: ________________________ **Date:** ____________________

NOTES: ____

____

____