

Patient Information

Patient Name: _____ **Date:** _____

Gender: _____ **Family Status:** _____

SSN: _____ **Birth Date:** _____

Phone (Home): _____ **(WORK):** _____ **Ext:** _____

Cell Phone: _____ **Email:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Health Information

Date of Last Dental Visit: _____ **Reason for visit:** _____

Have you ever had any of the following? Please check those that apply:

- | | | | | |
|---|---|---|---|---|
| <input type="checkbox"/> Aids | <input type="checkbox"/> Cancer | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mental Disorder | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nervous Disorder | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Growths | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Hepatitis A B C | <input type="checkbox"/> Radiation | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Latex Allergy |
| <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> High/Low Pressure | <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Congenital Heart Lesions | <input type="checkbox"/> Excessive bleeding | <input type="checkbox"/> Mitro Valve Prolapse | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Other _____
<input type="checkbox"/> Pregnancy Due Date _____ |

• Have you ever had any complications following dental treatment? Yes No
 If yes, please explain: _____

• Have you been admitted to a hospital or needed emergency care during the past two years?
 Yes No if yes, please explain: _____

- Are you now under the care of a physician? ___Yes ___No
If yes, please explain: _____
- Name of Physician: _____
Phone: _____
- Do you have any health problems that need further clarification? ___Yes ___No
If yes, please explain: _____
- Do you need to pre-medicate prior to a dental appointment? _____
If yes, which antibiotic? _____
- Do you have a persistent cough or cough up blood? _____
- What medications are you currently taking on a regular basis? _____
- Are you allergic to any medications? _____
- Do you use tobacco products? _____
- Are you HIV Positive? _____

Women Only

- Is there a possibility that you might be pregnant? _____
- Are you taking any oral contraceptives? _____
- Are you nursing? _____

Dental History

- How long since you last dental visit? _____
- What was done then? _____
- Did you have X-Rays taken? _____
- Have you lost any teeth? _____
- Are your teeth sensitive to heat? _____ Cold? _____ Sweets? _____ Sour? _____
- How often do you brush your teeth? _____
- Do you use dental floss? _____ How often? _____
- Do you have bleeding gums? _____ When? _____
- Do you grind your teeth? _____ When? _____
- Have you ever had gum treatments? _____ When? _____
- Are you aware of any swelling or lump in your mouth? _____
- Do you hear popping, clicking, or snapping noises when you chew? _____
- Have you had any serious trouble associated with any previous treatments? _____
If so, explain _____

Please describe any current medical treatment, impending operations, or any other medical or dental information that may possibly affect your dental treatment.

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ **date:** _____

Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? _____

___ Yellow Pages ___ Newspaper ___ Other

Employment Information

Employer Name: _____ Occupation: _____

Work Phone: _____ EXT: _____ Email: _____

Address _____

City _____ State _____ Zip _____

Insurance Information

Insurance Holders Name _____ **Insured Birth Date** _____

Insurance Plans Name and Address

ID # _____ Group # _____ Phone # _____ Payer ID # _____

Insured's Employer _____

Patient's relationship to the insured? ___ Self ___ Spouse ___ Child ___ Other

Spouse or Responsible Party Information

Name: _____

SSN# _____ Phone: _____ Birth Date: _____

Address: _____

City: _____ State: _____ Zip _____

Patients Signature: _____

Doctors Signature: _____