

Patient Information

Patient Name _____ Gender (M/F) _____ Marital Status _____

Birth Date _____ Social Security # _____

Address _____

_____ Email Address _____

Phone: Home _____ Work _____ (Ext) _____ Cell _____

Employer Name _____ Occupation _____

Employer Address _____

Name of person, office or other source that referred you to our practice _____

Responsible Party Information

If responsible party is the patient, please check here , skip this section and continue to Dental Insurance Information

Name _____ Gender (M/F) _____ Marital Status _____

Birth Date _____ Social Security # _____

Address _____

_____ Email Address _____

Phone : Home _____ Work _____ (Ext) _____ Cell _____

Employer Name _____ Occupation _____

Employer Address _____

Dental Insurance Information

If Insured Employee is patient , responsible party , please check correct box and begin at Insured's Insurance ID #

Name of Insured Employee _____ Gender (M/F) _____ Marital Status _____

Insured's Date of Birth _____ Insured's Social Security # _____

Insured's Address _____

Phone: Home _____ Work _____ (Ext) _____ Cell _____

Email Address _____

Insured's Employer Name & Address _____

Insured's Insurance ID # _____ Insured's Group # _____

Insurance Company Name, Address & Phone _____

_____ Patient's Relationship to Insured Self Spouse Child Other

(If you have secondary dental insurance, please inform us)

Dental History

Reason for today's visit _____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last Full Mouth X-rays (if known) _____

Please check "Yes" if you have, or had any of the following

Bad breath Yes

Bleeding Gums Yes

Blisters on lips/mouth Yes

Tobacco use Yes

Clicking or popping jaw Yes

Dental implants Yes

Food collection between the teeth Yes

Grinding teeth Yes

Gums swollen, tender Yes

Jaw pain or tiredness Yes

Lip or cheek biting Yes

Loose teeth Yes

Broken fillings Yes

Mouth breathing Yes

Pain upon brushing Yes

Orthodontic treatment Yes

Pain around ear Yes

Periodontal treatment Yes

Sensitivity to cold Yes

Sensitivity to heat Yes

Sensitivity to sweets Yes

Sensitivity when biting Yes

Sores or growths in your mouth Yes

Teeth whitening Yes

TMJ treatment, or pain Yes

How often do you floss? _____

How often do you brush? _____

Please continue to other side →

Health History

Physician's Name, Address and Phone _____

Date of Last Visit _____

Please check "Yes" if you have, or had any of the following

AIDS/HIV Yes
Allergies, Yes
list _____
Anemia Yes
Arthritis Yes
Artificial Heart Valves Yes
Artificial Joints Yes
Asthma Yes
Abnormal Bleeding Yes
Bacterial Endocarditis Yes
Blood Disease Yes
Cancer Yes
Chemical Dependency Yes
Circulatory Problems Yes
Cortisone Treatments Yes
Diabetes Yes
Emphysema Yes
Epilepsy Yes

Fainting or Dizziness Yes
Glaucoma Yes
Headaches or
Migraines Yes
Heart Murmur Yes
Heart Problems Yes
Hepatitis, Type ____ Yes
Herpes Yes
High Blood Pressure Yes
Hospitalized in past
5 years Yes
Kidney Disease Yes
Liver Disease Yes
Mitral Valve Prolapse Yes
Pacemaker Yes
Psychiatric Care Yes
Radiation Treatment Yes
Respiratory Disease Yes
Rheumatic Fever Yes
Sinus Trouble Yes

Stroke Yes
Thyroid Problems Yes
Tuberculosis Yes
Tumor or growth in
head or neck Yes
Ulcers or Digestive Yes
problems
Venereal Disease Yes
Need to premedicate Yes
prior to dental visit
Any other medical Yes
conditions. List _____

Women: Are you pregnant? Yes Due date _____ Are you nursing? Yes
Taking birth control pills? Yes Taken medications for osteoporosis? Yes

Medications

List any medications you are currently taking, and why you are taking it

Pharmacy Name _____ Phone _____

In Case of Emergency, Notify

Name _____ Relationship _____

Phone: Home _____ Work _____ (Ext) _____ Cell _____

Affirmation and Acknowledgement

I affirm that the information I have given today is correct to the best of my knowledge. I understand the this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes.

I grant permission to you or your assignee, to communicate with other health professionals concerning my dental care.

I understand that I am financially responsible for all charges, whether or not paid by insurance. If my account has to be sent to an attorney or collection agency, I will be responsible for all legal and collection fees incurred by this office.

Patient, Parent, or Guardian Signature

Date