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PATIENT INFORMATION

NAME: _____ Today's Date: _____

I prefer to be called: _____ ☐ Male ☐ Female Marital Status: _____

Birthdate: ____/____/____ Age: _____ Social Security Number: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone # (_____) _____ Work Phone # (_____) _____

Cell Phone # (_____) _____ Email _____

Employer: _____ Occupation: _____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

Other family members seen by us: _____

BILLING INFORMATION

PERSON RESPONSIBLE FOR THIS ACCOUNT, if other than patient: His/her Name: _____

Home Address: _____ City: _____ State: ____ Zip: _____

Relationship to the patient: _____ Birthdate: ____/____/____ SS #: _____

Home Phone # (____) _____ Work Phone # (____) _____ Employer: _____

DENTAL INSURANCE

PRIMARY DENTAL INSURANCE: Dental Insurance Co. Name: _____

Insurance Co. Phone # (____) _____ Group # _____

Insured's Name: _____ Insured's SS/ID # _____ Insured's Birthdate: ____/____/____

Relationship to Patient: ❑ Self ❑ Spouse ❑ Parent Insured's Employer: _____

DO YOU HAVE OTHER DENTAL INSURANCE COVERAGE? ❑ Yes ❑ No This coverage is through: ❑ Spouse ❑ Parent ❑ Other

Their Name: _____ Their SS/ID # _____

Their Birthdate: ____/____/____ Their Employer: _____

SECOND DENTAL INSURANCE CO.: Name: _____

2nd Insurance Co. Phone # (____) _____ Group # _____

In event of an EMERGENCY, who may we contact? Name: _____ Relationship: _____

Home Phone # (____) _____ Work Phone # (____) _____

DENTAL HISTORY

Why have you come to the dentist today? _____

_____

How may times a day do you brush? _____ floss? _____

When was your last dental visit? _____

When was your last full mouth x-ray? _____

When was your last complete dental exam? _____

Name of previous dentist? _____

Phone # (____) _____

May we contact this office for your records? _____

	YES	NO
Are you currently in PAIN?	❑	❑
Have you ever had a difficult problem associated with previous dental treatment?	❑	❑
Are you under any unusual stress at home or work?	❑	❑
Are you APPREHENSIVE about dental treatment?	❑	❑
Have you ever experienced TMJ problems?	❑	❑
Do you grind or clench your teeth?	❑	❑
Are your teeth sensitive to cold, sweets or pressure?	❑	❑
Do your gums ever bleed?	❑	❑
Have you ever had gum treatments?	❑	❑
Would you consider orthodontics?	❑	❑
Do you wear dentures?	❑	❑
If so, are you happy with them?	❑	❑
Would you like to prevent dentures?	❑	❑
Would you like your smile to look better?	❑	❑

OVER

MEDICAL HISTORY

Do you have a personal physician? ❑ Yes ❑ No Their name: _____

Phone # (____) _____ The approximate date of your last doctor's visit: _____

Are you currently under the care of any physician? ❑ Yes ❑ No If yes, please explain _____

_____

Do you smoke or use tobacco in any other form? ❑ Yes ❑ No

Are you presently taking any prescription or non-prescription medications? ❑ Yes ❑ No If yes, please list: _____

_____

For Women: Are you pregnant? ❑ Yes ❑ No Do you take birth control pills? ❑ Yes ❑ No Are you presently nursing? ❑ Yes ❑ No

Have you ever had any of the following diseases or medical problems? Check all that apply

❑ Heart Attack/Stroke
❑ Heart Surgery/Pacemaker
❑ Congenital Heart Defect
❑ Angina
❑ High/Low Blood Pressure
❑ Heart Murmur
❑ Rheumatic Fever
❑ Mitral Valve Prolapse
❑ Artificial Bones/Joints:
Circle: Hip / Knee / Heart Valve

❑ Hemophilia
❑ Abnormal Bleeding/Bruising
❑ Anemia
❑ Asthma
❑ Sinus Problems/Hay Fever
❑ Allergies/Hives
❑ Emphysema
❑ Glaucoma
❑ Severe Frequent Headaches

❑ Ulcers
❑ Arthritis
❑ Cancer/Chemotherapy
❑ Diabetes
❑ Thyroid Disease
❑ Psychiatric Problems
❑ Depression/Anxiety
❑ Hepatitis/Liver Disease
❑ AIDS/HIV
❑ Latex Allergy

Are you allergic to any of the following drugs?

❑ Penicillin
❑ Dental Anesthetics
❑ Tetracycline
❑ Codeine
❑ Aspirin
❑ Erythromycin

List any other drugs you are allergic to: _____

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 of 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 with my informed consent that I may need during diagnosis and treatment.

Signature: _____ Date: _____

Thank you for filling out this form completely. It will enable us to help you more effectively.

OFFICE USE ONLY – MEDICAL HISTORY UPDATE

I verbally reviewed the medical/dental information above with the patient named herein. Initials _____ Date _____

Doctor's Comments: _____

_____

Date _____ Comments _____ Signature _____

Date _____ Comments _____ Signature _____

Date _____ Comments _____ Signature _____

Date _____ Comments _____ Signature _____