PATIENT INFORMATION

(Please Print)

Name: ______________________________ Birth Date: __________ SS# ____ - ____ - ____
First MI Last

Address: ______________________ City: ______________ State ______ Zip: ______

E-mail Address ______________________________

Home Phone: ______________ Cell # ______________ Work # ______________

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Other

Parent or Guardian's Name (if patient is a minor) ______________________________

Patient or Parent/Guardian's Employer ______________________________

Employer Address: ______________________ City: ______________ State: ______ Zip: ______

If patient is a student, name of school/college ______________________________

Whom may we thank for referring you? ______________________________

Emergency Contact & Relationship ______________________________ Phone ______________

RESPONSIBLE PARTY (if other than patient)

Name of Person Responsible for Account ______________________ Birth Date ______________

Relationship to Patient ______________________ Driver's License # ______________

Address ______________________ City ______________ State ______ Zip ______

Employer ______________ Work # ______________ Home # ______________ Cell # ______________

Is this person currently a patient in our office? ☐ YES ☐ NO

INSURANCE INFORMATION

Name of Subscriber ______________________ SS # ______________

Subscriber Birth Date ____/____/19____ Relationship to Patient ______________

Name of Employer ______________________ Work # ______________

Employer Address ______________ City ______________ State ______ Zip ______

Insurance Co. ______________ Subscriber ID ______________ Group # ______________

Do you have any additional insurance? ☐ Yes ☐ No If yes, please complete the following

Name of Subscriber ______________________ SS # ______________

Subscriber Birth Date ____/____/19____ Relationship to Patient ______________

Name of Employer ______________________ Work # ______________

Employer Address ______________ City ______________ State ______ Zip ______

Insurance Co. ______________ Subscriber ID ______________ Group # ______________

X ____

Signature of patient or parent/guardian

SIGNATURE

PATIENT MEDICAL HISTORY

Physician Office Phone Date of Last Exam

1. Are you under medical treatment now? ☐ YES ☐ NO
2. Have you ever been hospitalized for any surgical operation or serious illness? ☐ YES ☐ NO
3. Are you taking any medication(s) including non-prescription? ☐ YES ☐ NO
   If yes, what are you taking? ______
4. Do you use tobacco? ☐ YES ☐ NO
5. Do you use alcohol? ☐ YES ☐ NO
   If yes, how many drinks per week? ______
6. Do you use cocaine or other drugs? ☐ YES ☐ NO
7. Are you allergic or have you had reactions to the following? **If NONE apply, please initial here:** ______
   - ☐ Local Anesthetics (i.e. novacaine)
   - ☐ Penicillin
   - ☐ Sulfa Drugs
   - ☐ Sedatives
   - ☐ Barbituates
   - ☐ Other Antibiotic(s)
   - ☐ Aspirin
   - ☐ Iodine
   - ☐ Other(s) ______
8. WOMEN ONLY:
   a. Are you pregnant or think you may be pregnant? ☐ YES ☐ NO
   b. Are you nursing? ☐ YES ☐ NO
   c. Are you taking birth control pills or other hormones? ☐ YES ☐ NO
9. Do you have, or have you had any of the following?
   Please check all that apply. **If NONE apply, please initial here:** ______

☐ High Blood Pressure	☐ Heart Disease	☐ Chest Pains
☐ Heart Attack	☐ Cardiac Pacemaker	☐ Easily Winded
☐ Rheumatic Fever	☐ Heart Murmer	☐ Stroke
☐ Swollen Ankles	☐ Angina	☐ Allergies
☐ Hay Fever	☐ Fainting	☐ Seizures
☐ Frequently Tired	☐ Tuberculosis	☐ HIV / AIDS
☐ Asthma	☐ Anemia	☐ Low Blood Pressure
☐ Radiation Therapy	☐ Cancer	☐ Leukemia
☐ Emphysema	☐ Glaucoma	☐ Epilepsy
☐ Convulsions	☐ Recent Weight Loss	☐ Arthritis
☐ Liver Disease	☐ Diabetes	☐ Mitral Valve Prolapse
☐ Joint Replacement / Implant	☐ Kidney Disease	☐ Hepatitus
☐ Jaundice	☐ Respiratory Problems	☐ Thyroid Problem
☐ Sexually Transmitted Disease	☐ Stomach Ulcers	☐ Stomach Troubles

☐ Other ______

Dentist and Hygienist Comments ______

PATIENT DENTAL HISTORY

Please check all that apply.

- ☐ My gums bleed while brushing or flossing.
- ☐ My teeth are sensitive to sweet/sour liquids/foods.
- ☐ I have sores or lumps in or near my mouth.
- ☐ I have experienced jaw related problems:
  - ☐ clicking
  - ☐ pain (joint, ear, side or face)
  - ☐ difficulty in opening or closing
  - ☐ difficulty in chewing
- ☐ I have been instructed on the correct method of brushing my teeth.
- ☐ I have been instructed on proper gum care.
- ☐ My teeth are sensitive to hot or cold liquids.
- ☐ I feel pain in one or more teeth.
- ☐ I have had head, neck or jaw injuries.
- ☐ I clench or grind my teeth.
- ☐ I frequently bite my lips and/or cheecks.
- ☐ I have had difficult extractions in the past.
- ☐ I have had orthodontic work.
- ☐ I have frequent headaches.
- ☐ I have experienced prolonged bleading following extractions.

Last Dental Visit: ______

Are you happy with your smile? ______