Patient Information

Full Name ____________________

Address ____________________

City ____________ State ________ Zip ________

Patient Or Parent's Employer ____________________

Employer's Address ____________________

City ____________ State ________ Zip ________

If Pt Is A Student, Name Of School ____________________

City ____________________ State ____________

Whom May We Thank For Referring You? ____________________

Birthdate (MM/DD/YYYY)

____

Home Phone

____

Work Phone

____

Email ____________________

Circle Appropriate Selection:

Minor Single Married

Divorced Widowed Seperated

Responsible Party

Full Name Of Responsible Party For This Account

____

____

Address ____________________

City ____________ State ________ Zip ________

Employer ____________________

Employer Address ____________________

City ____________ State ________ Zip ________

Relationship To Patient ________

Home Phone ____________

Work Phone ____________

Cell Phone ____________

Birthdate (MM/DD/YYYY)

____

SS Number ____________

Insurance Information

Name Of Insured ____________________

Insurance Company ____________________

Relationship To Patient

____

Insurance Address____

City ______________________ State _____________ Zip ____________

Group Number ________________ Group Name _____________________

Birthdate (MM/DD/YYYY)
____

SS Number ____________________

Insurance Phone _____________

Additional Insurance Information

Name Of Insured ____

Insurance Company ____

Insurance Address____

City ______________________ State _____________ Zip _________

Relationship To Patient ________

Birthdate (MM/DD/YYYY)
____

SSN Number ___________________

Group Number ________________

Insurance Phone ________________

Medical Information

Are You Under The Care Of A Physician? Yes No
If yes, physician name and phone number
____
____
Have You Been Hospitalized In The Last Five Years? Yes No
Are You Taking Medications? Including Over The Counter And Prescription
Yes No
Please list all medications: ______________________________________
Do You Use Tobacco? Yes No

Do You Use Alcohol? Yes No
Do You Use Cocaine Or Other Drugs? Yes No
Do You Wear Contacts? Yes No
Do You Have Any Known Drug Allergies? Yes No
If yes, please list below:
____
____

Have You Ever Had A Reaction To Anesthetic? Yes No
Do you have a prosthetic device, pace maker,
or any artificial joints? Yes No
If yes, please describe:____________________________________
____

Date Of Last Physical Exam
____

Women Only:

Are You Pregnant? ______________
Are You Nursing? _______________
Are You Taking Birth Control Pills?
____

Please Check The Following About Yourself:

High Blood Pressure	___ ___	Frequently Tired	___ ___	Aids/HIV Infection	___ ___
Heart Attack	___ ___	Anemia	___ ___	STD's	___ ___
Rheumatic Fever	___ ___	Emphysema	___ ___	Thyroid Problems	___ ___
Swollen Ankles	___ ___	Cancer	___ ___	Hepatitis A, B Or C	___ ___
Faining/Seizures	___ ___	Arthritis	___ ___	Ulcers	___ ___
Asthma	___ ___	Joint Replacement	___ ___	Respiratory Problems	___ ___
Low Blood Pressure	___ ___	Chest Pains	___ ___	Other ______________________	
Epilepsy/Convulsions	___ ___	Short Of Breath	___ ___	______________________	
Leukemia	___ ___	Stroke	___ ___	______________________	
Diabetes !	___ ___	Hay Fever/Allergies	___ ___	______________________	

Diabetes II	___	___	Tuberculosis	___	___	________________
Heart Disease	___	___	Radiation Therapy	___	___	
Cardiac Pace Maker	___	___	Glaucoma	___	___	________________
Heart Murmer	___	___	Liver Disease	___	___	
Angina	___	___	Kidney Disease	___	___	

Dental History

Please Write Yes or No

- Do Your Gums Bleed While Brushing Or Flossing? ________
- Are Your Teeth Sensitive To Hot Or Cold Liquids/Foods? ________
- Are Your Teeth Sensitive To Sweet Or Sour Liquids/Foods? ________
- Do You Feel Pain In Any Of Your Teeth? ________
- Do You Have Any Sores Or Lumps In Your Mouth? ________
- Have You Ever Suffered Trauma To Your Face Mouth Or Jaw? ________
- Does Your Jaw Ever Click, Pop, Crackle Or Ache? ________
- Do You Have Pain In Your Jaw Joint, Ear Or Side Of The Face? ________
- Do You Have Difficulty Opening Or Closing Your Mouth? ________
- Do You Have Difficulty Chewing? ________
- Do You Have Frequent Headaches? ________
- Do You Clench Or Grind Your Teeth? ________
- Do You Bite Your Lips Or Cheeks Frequently? ________
- Have You Had Problems With Previous Dental Work? ________
- Have You Ever Had Braces? ________
- How Many Times A Day Do You Brush Your Teeth? ________
- How Often Do You Floss? ________
- Do You Use A Manual Brush Or Electric? ________
- Do You Use Any Type Of Mouth Rinse? ________

Goals For Your Mouth, Teeth And Smile: ____________________________________

____

____

If You Could Change Anything About Your Smile, What Would That Be?

____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been answered accurately. I understand that providing false or incorrect information can be dangerous to my health.

____

PATIENT SIGNATURE DATE

____

PRINT NAME

____

Dentist Signature

Date________________________________

____

Witness Signature

Date

____