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## Patient Information

Patient Name: Last, ________ First, ________ Preferred ________ Gender: ☐ Male ☐ Female

Social Security #: ________ Birth Date: ________ ☐ Married ☐ Single ☐ Child

Phone (Home): ________ (Work): ________ (Cell): ________

Email address: ________

Physical Address: Street ________

City ________ State ________ Zip Code ________

Billing Address: Street ________

City ________ State ________ Zip Code ________

***In the event of an emergency, whom should we contact?*** Name: ________ Phone: ________

## Employment Information

Employer Name: ________ Occupation: ________

## Insurance Information

Dental Coverage ☐ Yes ☐ No

Insurance Plan Name: ________

Insurance Plan Phone#: ________

Group# (Plan, Local or Policy#): ________

Insured's Name: ________ Relation: ________

Insured's Birth date: ________ Insured's ID# or S.S.#: ________

Insured's Employer: ________ ________

Employer's Address: ________

## Secondary Insurance

Dental Coverage ☐ Yes ☐ No

Insurance Plan Name: ________

Insurance Plan Phone#: ________

Group# (Plan, Local or Policy #): ________

Insured's Name: ________ Relation: ________

Insured's Birth date: ________ Insured's ID # or S.S. #: ________

Insured's Employer: ________

Employer's Address: ________

*Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.*

Primary reason for seeing the dentist today? ________

________

I want to improve my smile ☐ Happy with my smile ☐

## Referral Information

Whom may we thank for referring you to our practice? ☐ Another Patient ☐ Provider List ☐ Location

☐ Internet ☐ Work ☐ Other ________

Name of person or office referring you to our practice: ________

## Medical History Information

| | YES | NO |
|---|---|---|
| Are you currently under any medical treatment now? | O | 0 |
| Have you ever been hospitalized for any surgical operation or serious illness? | O | 0 |
| Do You ***currently*** need antibiotic **Pre-Med** for dental appointments? | O | 0 |

### Allergies

| | | | |
|---|---|---|---|
| 0 | Aspirin | 0 | Barbiturates (sleeping pills) |
| 0 | Codeine | 0 | Iodine |
| 0 | Latex | 0 | Local Anesthetic Allergy |
| 0 | Metal | 0 | Penicillin |
| 0 | Sulfa | 0 | Other Allergy: ____________ |

### Medications

List any medications you are currently taking and the correlating diagnosis: ______________________________

0 **NONE** ______________________________

### Do you have or have you had any of the following?

| YES | NO | | YES | NO | | YES | NO | |
|---|---|---|---|---|---|---|---|---|
| 0 | 0 | AIDS/HIV | 0 | 0 | Hay Fever/Allergies | 0 | 0 | Rheumatic Fever |
| 0 | 0 | ADHD | 0 | 0 | Headaches | 0 | 0 | Scarlet Fever |
| 0 | 0 | Anemia | 0 | 0 | Heart Murmur | 0 | 0 | Shortness of Breath |
| 0 | 0 | Arthritis, Rheumatism | 0 | 0 | Heart Problems | 0 | 0 | Sinus Trouble |
| 0 | 0 | Artificial Heart Valves | 0 | 0 | Hepatitis Type ____________ | 0 | 0 | Skin Rash |
| 0 | 0 | Artificial Joints | 0 | 0 | Herpes | 0 | 0 | Special Diet |
| 0 | 0 | Asthma | 0 | 0 | High Blood Pressure | 0 | 0 | Stroke |
| 0 | 0 | Back Problems | 0 | 0 | High Cholesterol | 0 | 0 | Swollen Feet or Ankles |
| 0 | 0 | Bleeding abnormally | 0 | 0 | Jaundice | 0 | 0 | Swollen Neck Glands |
| 0 | 0 | Blood Disease | 0 | 0 | Kidney Disease | 0 | 0 | Thyroid Problems |
| 0 | 0 | Cancer | 0 | 0 | Liver Disease | 0 | 0 | Tonsillitis |
| 0 | 0 | Chemical Dependency | 0 | 0 | Low Blood Pressure | 0 | 0 | Tuberculosis |
| 0 | 0 | Chemotherapy | 0 | 0 | Mitra[ Valve Prolapse | 0 | 0 | Tumor/growth on head/neck |
| 0 | 0 | Circulatory Problems | 0 | 0 | MS | 0 | 0 | Ulcer |
| 0 | 0 | Congenital Heart Lesions | 0 | 0 | Nervous Problems | 0 | 0 | Venereal Disease |
| 0 | 0 | Cortisone Treatments | 0 | 0 | Pre-Med with Antibiotics | 0 | 0 | Weight Loss, unexplained |
| 0 | 0 | Emphysema | 0 | 0 | Psychiatric Care/ Depression/Anxiety | | | |
| 0 | 0 | Epilepsy | | | | | | |
| 0 | 0 | Fainting or dizziness | 0 | 0 | Radiation Treatment | | | |
| 0 | 0 | Diabetes | 0 | 0 | Pacemaker | | | |
| 0 | 0 | Glaucoma | 0 | 0 | Respiratory Disease | | | |

**Women:**

| | YES | NO |
|---|---|---|
| Are you Pregnant<br>Due date ____________ | 0 | 0 |
| Are you nursing? | 0 | 0 |

## Dental History

Do you have or have you had any of the following?

| YES | NO | | YES | NO | |
|---|---|---|---|---|---|
| 0 | 0 | Bad Breath | 0 | 0 | Loose teeth or broken fillings |
| 0 | 0 | Bleeding gums | 0 | 0 | Mouth breathing |
| 0 | 0 | Blisters on lips or mouth | 0 | 0 | Mouth pain, brushing |
| 0 | 0 | Burning sensation on tongue | 0 | 0 | Orthodontic treatment |
| 0 | 0 | Cigarette, pipe, or cigar smoking | 0 | 0 | Pain around ear |
| 0 | 0 | Clicking or popping jaw | 0 | 0 | Periodontal treatment |
| 0 | 0 | Dry mouth | 0 | 0 | Sensitivity to Cold |
| 0 | 0 | Fingernail biting | 0 | 0 | Sensitivity to Hot |
| 0 | 0 | Food collection between teeth | 0 | 0 | Sensitivity to Sweets |
| 0 | 0 | Foreign objects (piercings) | 0 | 0 | Sensitivity when biting |
| 0 | 0 | Gums swollen or tender | 0 | 0 | Smokeless Tobacco (Chew) |
| 0 | 0 | Jaw pain or tiredness | 0 | 0 | Sores or growths In mouth |
| 0 | 0 | Lip or cheek biting | | | |

How often do you floss? ____________ How often do you brush? ___________

To the best of my knowledge, all of the proceeding 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. I understand that providing incorrect information can be dangerous to my health.

______________________________________________ Date: _______________

Signature of Patient (Parent or Guardian)