Patient Information: Marital Status: *Single Married Widowed*

Full Name _____ Nickname _____

Address _____ City _____ State Zip Code _____

_____ _____

Phone: Mobile ( )_____-_____ Home ( )_____-_____ Work ( )_____-_____

Sex: M F Date of Birth ___/___/_____ S.S.# ___-____-_____ Email:_____

Emergency Contact _____ Telephone ( )___-_____ Relation to patient _____

Responsible Party:

Relation to Patient: *Self Spouse Parent Guardian Facility* Occupation: _____

Full Name _____ Nickname _____

Address _____ City _____ State Zip Code _____

_____ _____

Phone: Mobile ( )_____-_____ Home ( )_____-_____ Work ( )_____-_____

Sex: M F Date of Birth ___/___/_____ S.S.# ___-____-_____ Email:_____

Insurance Information:

Dental Insurance Company: _____ Employer: _____

Subscriber: _____ Date of Birth: ___/___/_____ Subs. ID/SSN:_____

Dental Insurance Company: _____ Employer: _____

Subscriber: _____ Date of Birth: ___/___/_____ Subs. ID/SSN:_____

Medical History:

	Yes	No		Yes	No		Yes	No
Angina/Chest Pain	☐	☐	Drug abuse history	☐	☐	_____cancer	☐	☐
Heart Attack/ Failure	☐	☐	Cerebral Palsy	☐	☐	Leukemia	☐	☐
Heart disease	☐	☐	Convulsions	☐	☐	Rheumatic Fever	☐	☐
Heart murmur	☐	☐	Alzheimer's disease	☐	☐	Anemia	☐	☐
Heart surgery	☐	☐	Rheumatism	☐	☐	Fainting/Dizziness	☐	☐
Heart Valve problems	☐	☐	Tuberculosis	☐	☐	High Blood Pressure	☐	☐
Stroke	☐	☐	Asthma	☐	☐	Kidney problems	☐	☐
Bleeding problem	☐	☐	Breathing problem	☐	☐	Liver Disease	☐	☐
Excessive bleeding	☐	☐	Emphysema	☐	☐	Dialysis	☐	☐
Diabetes	☐	☐	Lung disease	☐	☐	Blood transfusion	☐	☐
Artificial joint	☐	☐	Crohn's Disease	☐	☐	Hepatitis	A	B C
AIDS	☐	☐	Cortisone medicine	☐	☐	Sickle cell disease	☐	☐
HIV positive	☐	☐	Respiratory disease	☐	☐	Thyroid problem	☐	☐
Venereal disease	☐	☐	Shortness of breath	☐	☐	Arthritis	☐	☐
Genital herpes	☐	☐	Headaches	☐	☐	Head injury	☐	☐
Pregnant _____mos	☐	☐	Deaf	☐	☐	Hives or rash	☐	☐
Nursing	☐	☐	Earache	☐	☐	Skin sores/Blisters	☐	☐
Grinding of teeth	☐	☐	Hearing problems	☐	☐	Tumors/Growths	☐	☐
Pain in jaw joints	☐	☐	Parkinson's disease	☐	☐	Bruise easily	☐	☐

Additional Information? _____

Allergies:

☐ Acrylic	☐ Latex	☐ Metal; type _____
☐ Acetaminophen	☐ Aspirin	☐ Ibuprofen
☐ Amoxicillin	☐ Penicillin	☐ Sulfa
☐ Codeine	☐ Tylenol	☐ Motrin

Use of Tobacco?

Yes/No

Other: _____

Medications:

Please list all current _____

_____

Primary Care Physician: Physician name _____ Telephone ( )_____-_____

Due to a pre-existing medical condition, is pre-medication required for dental treatment? YES NO

If *yes*, please specify medication and instructions _____

Purpose of today's visit _____ Date of last dental visit _____ Referred by _____

By signing below, I agree that I am the legally responsible party of the patient, I have read and understand the privacy practices related to this office (The Health Insurance Portability and Accountability Act [HIPPA]), I verify that the information on this form is current and correct to the best of my knowledge, and I will update this information , accordingly, before treatment is performed.

_____ _____ _____

Patient Information and Dental History

1. Have we seen you or any member of your family before? _____
2. Date of last Dental Examination _____ Dentist's name _____
3. Date of last Dental X-Rays _____

Circle

Yes No 4. Are you having pain or discomfort at this time? If yes, please describe: _____

_____

Yes No 5. Do you feel very nervous about having dental treatment? _____

Yes No 6. Have you ever had a bad experience in a dental office? _____

Yes No 7. Is there anything that you dislike about your smile? _____

Yes No 8. Have you ever had any instructions in oral hygiene? _____

Yes No 9. Are there now any growths or sores in or around your mouth? _____

Yes No 10. Do you have any trouble chewing? _____

Yes No 11. Does food catch between your teeth? _____

Yes No 12. Do you have pain in or near your ears? _____

Yes No 13. Do you habitually clench or grind your teeth during the day or night? _____

Yes No 14. Have you ever been told that you have gum problems? _____

Yes No 15. Do you now have bleeding gums or any other gum problems? _____

Yes No 16. Is there anything else related to your medical or dental history that you have not indicated above? If yes, please explain. _____

_____