

Patient Information

Patient Name: _____ Date: 06/27/2010

_____ Last, _____ First _____ MI (Preferred Name)

Birth Date: _____ Male Female

Social Security #: _____ Married Single Child Other _____

Phone (Home): _____ (Work): _____ (Cell): _____

Would you like appointment confirmation by Phone Text Email

Email: _____

Address: _____

Street

Apt #

City

State

Zip

Emergency Contact: _____ Emergency Phone: _____

Referral Information

Whom may we thank for referring you to our practice?

Patient Website Internet Search Sign Mailer Insurance YellowPages Newspaper

Referral Name (if applicable): _____

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____

Address: _____

Street

Apartment #

City

State

Zip Code

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? Yes No

_____ Last _____ First _____ MI ID #: _____ Group #: _____

Insured's Address: _____

Street

City

State

Zip Code

Insured's Employer Name: _____

Address: _____

Street

City

State

Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ Is insured a patient? Yes No

_____ Last _____ First _____ MI ID #: _____ Group #: _____

Insured's Address: _____

Street

City

State

Zip Code

Insured's Employer Name: _____

Address: _____

Street

City

State

Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Health Information

Patient Name: _____

Have you experienced any of the following?

- | | | |
|--|--|---|
| <input type="checkbox"/> Angina/Chest Pain | <input type="checkbox"/> Fainting or Dizziness | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Pain in Jaw Joints |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Frequent Diarrhea / Urination | <input type="checkbox"/> Recent Weight Loss |
| <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Swollen Joints |

Are you allergic to:

- Penicillin Latex Aspirin Codeine Local anesthetic (Novacaine/Xylocaine) Nitous Oxide Valium
 Erthromycin Tetracycline Vicoden Percodan Food Metal Other: _____

Have you ever had any of the following? Please check those that apply:

- | | | |
|--|--|--|
| <input type="checkbox"/> AIDS (HIV+) | <input type="checkbox"/> Emphysema/Lung Disease | <input type="checkbox"/> Orthodontics |
| <input type="checkbox"/> Allergies (Pollen Dust) | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Glaucoma/Eye Disease | <input type="checkbox"/> Periodontal Treatment |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Arthritis/Gout/Rheumatism | <input type="checkbox"/> Heart Murmur/Irregularity | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Hepatitis A / B / C | <input type="checkbox"/> Scarlet/Rheumatic Fever |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Herpes | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Skin Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Cancer/Chemotherapy | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Stomach/Intestinal Problems |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Transplant |
| <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Drug/Alcohol Addiction | <input type="checkbox"/> Migraines | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Dry Mouth | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Veneral Disease |

Do you need to Pre-Medicate for your dental appointment? Yes No

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

Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
If yes, please explain _____

Women (please check) pregnant / trying to get pregnant Nursing Taking oral contraceptives

Have you taken any antibiotics, supplements, tobacco, alcohol, weight loss or any other medications in the last 3 months.
Drugs of any kind - please list: _____

Are you experiencing any dental problems now? _____

How often do you brush? _____ Floss? _____

Have you ever had a traumatic experience in a dental office? Yes No _____

Have you ever had any complications following dental treatment? Yes No _____

Check those that apply:

- Clench/grind teeth bleeding gums food collection in teeth pain/clicking/popping jaw sensitive teeth bad breath

Is there anything that you would like to change about your smile?

- Whiter teeth close spaces straighten teeth repair teeth change shape of teeth other: _____

Previous dentist: _____ Date of last full mouth x-rays? _____

To the best of my knowledge, all the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

Signature of patient, parent or guardian _____ Date: _____

Doctor: _____ Date: _____ Patient BP: _____