Patient Information

Patient's Name:			Date:
□ Male □ Female	□ Married □ Single □ Child □ Other		Social Security #:
Email:			Birth Date:
Phone (Home):	(work):	Ext:	(Cell):
Street Address:	City and State:		Zip code:

Patient Employment Information

Employer Name:	Occupation:	How long:
Street Address:	City and State:	
Zip Code:	Phone:	

Emergency Contact

Emergency Contact:	Phone:

Insurance Information

Primary Insurance Company Name:	ID #:	Group #:
Insured's Employer:	Insured's Birth Date:	Insurance Company Phone:
Insurance Company Address (Street):		(City,State,zip):
Name of insured (Last,First,MI):	Patient's Relationship to insured: □Self □Spouse □Child □Other	
Secondary Insurance Company Name:	ID #:	Group #:
Insured's Employer:	Insured's Birth Date:	Insurance Company Phone:
Insurance Company Address (Street):		(City,State,zip):
Name of Insured (Last,First,MI):	Patient's Relationship to insured: □Self □Spouse □Child □Other	

Responsible Party Information
(If other than patient, must be present to sign)

Name:		Social Security #:	DOB:
□ Male □ Female	□ Married □ Single □ Child □ Other	Email:	
Phone (Home):	Work:	Ext:	(Cell):
Address (Street, City, State, Zip):			

Referral Information

Whom may we thank for referring you to our practice?_____

Patient Name:	Date:

Health Information

Date of Last Dental Visit:	Reason for the visit:
What would you like us to do today?	Are you in discomfort today? □ Yes □ No
Former Dentist:	Phone:

Have you had any recent problems with any of the following? Please check yes or no:

□ Y □ N Bad Breath
□ Y □ N Food collection between teeth
□ Y □ N Sores or growths in mouth
□ Y □ N Sensitivity to sweets
□ Y □ N Bleeding Gums
□ Y □ N Grinding or clenching teeth
□ Y □ N Sensitivity to cold
□ Y □ N Sensitivity to hot
□ Y □ N Clicking or popping jaw
□ Y □ N Sensitivity when biting
□ Y □ N Loose teeth or broken fillings

How often do you brush?	Floss?

How do you feel about the appearance of your teeth?

Have you ever experienced an adverse reaction during or in conjunction with medical or dental procedure? □ Yes □ No

Other information about your dental health or previous treatment:

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

□ AIDS/HIV
□ Allergies:
- □ Codeine Allergy
- □ Latex/Rubber Allergy
- □ Metal Allergy
- □ Penicillin Allergy
- □ Sulfa Allergy
- □ Tylenol Allergy
- □ Other: _____

□ Arthritis/Rheumatism
□ Nervous Disorders
□ Artificial Joints
□ Artificial Valves
□ Asthma
□ Cancer
□ Chem. Dependency
□ Diabetes
□ Epilepsy
□ Excessive Bleeding
□ Head Injuries
□ Heart Disease
□ Fainting/Dizziness
□ Heart Murmur
□ Hepatitis
□ High Blood Pressure
□ Kidney Disease
□ Liver Disease
□ Mental Disorders
□ Mitral Valve Prolapse
□ Osteoporosis
□ Pacemaker
□ Periodontal Treatment
□ Pregnancy/Due Date: _____
□ Pre-med:_____
□ Radiation Treatment
□ Chemotherapy
□ Respiratory Problems
□ Sinus Problems
□ Stomach Problems
□ Stroke
□ Tobacco Use
□ Tuberculosis
□ Tumors
□ Other: _____
□ Other: _____

Have you ever used a bisphosphonate medication? Brand names include Fosamax, Actonel, Atelvia, Didronel, and Boniva. □ Yes □ No

Have you ever had any complications following dental treatment? □ Yes □ No
If yes, please explain:

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

Are you now under the care of a physician? □ Yes □ No
If yes, please explain:

Name of Physician:	Phone:

Are you taking ANY medications, pills, vitamins/supplements or drugs? □ Yes □ No
If yes, please List:_____

_____

To the best of my knowledge, all of 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.

_____ **Date:** _____

Signature of patient, parent or guardian