CONFIDENTIAL

PATIENT INFORMATION TODAY'S DATE:____________

(PLEASE PRINT)

MR / MRS / MS ______________________________ DATE OF BIRTH:____________
FIRST MI LAST

ADDRESS: ______________________ CITY: __________ STATE: _____ ZIP: ________

HOME PHONE: ______________ SS#: ______________ EMAIL: ______________

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

PATIENT'S OR PARENTS'S EMPLOYER ______________________ WORK PHONE: __________

SPOUSE OR PARENT'S NAME: ______________________ EMPLOYER: ______________

PERSON TO CONTACT IN CASE OF EMERGENCY: ______________ PHONE:__________

WHOM MAY WE THANK FOR REFERRING YOU? ______________________

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT ______________________

RELATIONSHIP TO PATIENT ______________ ADDRESS ______________

EMPLOYER ______________ HOME PHONE ______________ WORK PHONE ______________

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED ______________________ RELATIONSHIP TO PATIENT __________

DATE OF BIRTH ____________ SS# ______________ WORK PHONE ______________

NAME OF EMPLOYER ______________________ INS. COMPANY ______________

GROUP NUMBER______________

ANY ADDITIONAL / SECONDARY INSURANCE – PLEASE LIST BELOW

NAME OF INSURED ______________________ RELATIONSHIP TO PATIENT __________

DATE OF BIRTH ____________ SS# ______________ WORK PHONE ______________

NAME OF EMPLOYER ______________________ INS. COMPANY ______________

GROUP NUMBER______________

PLEASE COMPLETE BACK PAGE HEALTH INFORMATION

PATIENT MEDICAL HISTORY

MEDICAL DOCTOR ____________________ PHONE ________________ DATE OF LAST EXAM _____

1. ARE YOU UNDER MEDICAL TREATMENT NOW? Y N
2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS? Y N
   If YES, please list: ________________________
   ____
3. ARE YOU TAKING ANY MEDICATION (S), INCLUDING NON-PRESCRIPTION MEDICINES? Y N
   If YES, please list: ________________________
   ____
   ____
4. DO YOU USE TOBACCO? Y N
5. DO YOU USE ALCOHOL OR OTHER DRUGS? Y N
6. ARE YOU WEARING CONTACT LENSES? Y N
7. ARE YOU ALLERGIC TO OR HAD ANY REACTIONS TO ANY DRUGS? If YES, please list/explain:_______ Y N
   ____
   ____
8. WOMEN ONLY:
   a) ARE YOU PREGNANT OR THINK YOU MAY BE? Y N
      How many months? ___________
   b) ARE YOU NURSING? Y N
   c) ARE YOU TAKING BIRTH CONTROL PILLS? Y N

PLEASE INDICATE WHICH OF THE FOLLOWING APPLIES TO YOU. **CIRCLE ONLY IF ANSWER IS YES.**

High Blood Pressure	Heart Disease	Chest Pains	Kidney Disease
Heart Attack	Cardiac Pacemaker	Easily Winded	AIDS or HIV Infection
Rheumatic Fever	Heart Murmur	Stroke	Sexually Transmitted disease
Swollen Ankles	Angina	Hay Fever/Allergies	Thyroid Problems
Seizures/Fainting	Frequently Tired	Tuberculosis	Hepatitis/Jaundice
Asthma	Anemia	Radiation Therapy	Stomach Troubles/Ulcers
Low Blood Pressure	Emphysema	Glaucoma	Respiratory Problems
Epilepsy/Convulsions	Cancer	Recent Weight Loss	
Leukemia	Arthritis	Liver Disease	
Diabetes	Joint Replacement/Implant	Heart Trouble	

Please list any other medical conditions you may have that are not listed above:

____

____

DENTAL HISTORY

Date of last dental appointment ____________________

1. Do your gums bleed while brushing or flossing? Y N
2. Are your teeth sensitive to hot or cold liquids/foods? Y N
3. Are your teeth sensitive to sweet or sour liquids? Y N
4. Do you feel pain in any of your teeth? Y N
5. Do you have any sores or lumps in or near your mouth? Y N
6. Have you had any Head, Neck, or Jaw injuries? Y N
7. Do you have frequent headaches? Y N
8. Do you clench or grind your teeth? Y N
9. Do you bite your lips or cheeks often? Y N
10. Have you had any orthodontic (braces) work? Y N
11. Have you ever experienced any of the following problems in your jaw?
    - Clicking Y N
    - Pain Y N
    - Difficulty in chewing Y N
    - Difficulty in opening or closing Y N
12. Have you ever had difficult extractions in the past? Y N
13. Have you ever had prolonged bleeding following extractions? Y N
14. Have you ever had instruction on the correct method of brushing your teeth? Y N

X ____________________________
Signature of Patient, Parent, or Guardian

____
Date