



PATIENT INFORMATION

DATE: _____

PATIENT: (Ms., Mr., Mrs., Dr.) _____
(First) (M.I.) (Last) (Preferred)

MARITAL STATUS: Single ___ Married ___ Divorced ___ Widowed ___ Child ___ Sex: M ___ F ___

ADDRESS: _____
Street City State Zip

EMAIL ADDRESS: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

DATE OF BIRTH: _____ SOCIAL SECURITY # _____

EMPLOYER'S NAME: _____ OCCUPATION: _____

ADDRESS _____
Street City State Zip

SPOUSE'S NAME: _____ OCCUPATION: _____

SPOUSE'S EMPLOYER: _____ WORK PHONE: _____

BILLING INFORMATION (If different from above)

NAME OF RESPONSIBLE PARTY: _____
(First) (M.I.) (Last)

SEX: M ___ F ___

ADDRESS: _____
Street City State Zip

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

SOCIAL SECURITY # _____ EMPLOYER'S NAME: _____

ADDRESS: _____
Street City State Zip

DENTAL INSURANCE INFORMATION

INSURANCE COMPANY NAME _____ GROUP# _____

ADDRESS: _____
Street City State Zip

NAME OF INSURED PERSON _____ SOCIAL SECURITY# _____

DATE OF BIRTH _____ EMPLOYER OF INSURED _____

PLEASE FILL OUT
REVERSE SIDE ALSO

MEDICAL HISTORY

PHYSICIAN NAME: _____ PHONE: _____

ADDRESS: _____
Street
City
State
Zip

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No If yes, please explain: _____

Have you been hospitalized or had a major operation? Yes No If yes, please explain: _____

Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____

Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____

Do you use tobacco? Yes No

Do you use controlled substance? Yes No

Women: Are you
 Pregnant/Trying to get pregnant? Nursing?
 Taking oral contraceptives?

Are you allergic to any of the following?

- Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics
 Other If yes, please explain: _____

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

- | | | | | |
|---|--|--|--|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Radiation Treatments |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Recent Weight Loss |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Renal Dialysis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Heart Pace Maker | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Bisphosphonate Medications | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tumors or Growths |
| | | | | <input type="checkbox"/> Ulcers |

Any other diseases or problems? _____

Comments: _____

DENTAL HISTORY

How long since you have seen a Dentist? _____ What are your main dental concerns? _____

_____ Are you happy with the appearance of your teeth? _____

REFERRAL

Who may we thank for referring you to our office? _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____