PATIENT INFORMATION

DATE: ______________

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

MARITAL STATUS: Single_____ Married______ Sex: M______ F_______

ADDRESS: ____
Street City State Zip

EMAIL ADDRESS: ____

HOME PHONE: ________________ WORK PHONE: ________________ CELL PHONE: ______________

Would you like email confirmation? Yes or No Would you like text message confirmation? Yes or No

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)

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 _____________________________

MEDICAL 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?

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

Any other diseases or problems? ____

Comments: ____

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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_______________