Patient Informantion

Today's Date

Salute | Last Name | First Name | Sex | DOB | Age

Street Address | City | State | Zipcode

Email Address | Home | Cell | Work

Preferred Form Of Communication

Referred to us by:

Emergency Information

Name | Address | Telephone

Relationship to Patient

Account Information

Your Soc. Sec. # | Your Employer | Person Responsible for Account

If Minor: Parent's Name	Soc. Sec. #	DOB	Adress
Mom				
Dad				

Dental Insurance Information

PRIMARY COVERAGE	SECONDARY COVERAGE
Patient's (insured) Name	Patient's (insured) Name
Subscriber's Name	Subscriber's Name
Subscriber's DOB	Subscriber's DOB
Subscriber's SS #	Subscriber's SS #
Insurance Co.	Insurance Co.
Insurance Co. Address	Insurance Co. Address
Subscriber's Employer	Subscriber's Employer
Group #	Group #
ID #	ID #

MEDICAL INSURANCE INFORMATION

Patient's (Insured) Name

Subscriber's Name

Subscriber's DOB

Subscriber's SS #

Insurance Co.

Insurance Co. Address

Subscriber's Employer

Group #

ID #

It is important that I know about your Medical and Dental HIstory. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking

CHECK ANY OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

- ☐ **Heart Disease or Attack**
- ☐ **Rheumatic Fever**
- ☐ **Heart Pacemaker**
- ☐ **Stroke**
- ☐ **Hepatitis A (Infectious)**
- ☐ **Drug Addiction**
- ☐ **Nervousness**
- ☐ **High Blood Pressure**
- ☐ **Mitral Valve Prolapse**
- ☐ **Artificial Joints (hip, knee)**
- ☐ **Ulcers**
- ☐ **Liver Disease**
- ☐ **Fever Blisters**
- ☐ **Glaucoma**
- ☐ **Venereal Disease (Syphilis, Gonorrhea, etc.**
- ☐ **Asthma**
- ☐ **Diabetes**
- ☐ **Cortisone Medicine**

- ☐ Chemotherapy (Cancer, Leukemia)
- ☐ Bruise Easily
- ☐ Hay Fever
- ☐ Thyroid Disease
- ☐ Pain in Jaw Joints
- ☐ Angina Pectoris
- ☐ Congenital Heart Lesions
- ☐ Heart Surgery
- ☐ Kidney Trouble
- ☐ Hepatitis B (Serum)
- ☐ Hemophilia (Bleeding Problems)
- ☐ Psychiatric Treatment
- ☐ Tuberculosis (T.B.)
- ☐ Allergies or Hives
- ☐ Arthritis
- ☐ Cosmetic Surgery
- ☐ Heart Murmur
- ☐ Artificial Heart Valve
- ☐ Anemia
- ☐ Aids/HIV positive
- ☐ Blood Transfusion
- ☐ Epilepsy or Seizures

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING?

☐ Aspirin ☐ Local Anesthetic ☐ Erythromycin ☐ Nickel/other metals
☐ Nitrous Oxide ☐ Codeine ☐ Penicillin ☐ Sulfa

Are you aware of being allergic to any other medications or substances? if yes, please list:
Is there any other Medical or Dental information that you feel I should know about?

FAMILY PHYSICIAN:	PHONE Number:

Do you have any CURRENT HEALTH PROBLEMS?

Are you under a PHYSICIAN'S CARE now?

What are you under a physician's care now for?

Do you have any PINS or SCREWS in your joints, limbs, skull or anywhere in your body?

Where do you have PINS or SCREWS?

What MEDICATIONS are you currently taking?

Do you smoke?

For WOMEN: Are you PREGNANT, TRYING TO GET PREGNANT, ON BIRTH CONTROL?

HOW LONG SINCE you have seen a Dentist?

Last COMPLETE Dental Exam, Date:

What can we do for you TODAY?

Is your present dental health POOR?

Are you APPREHENSIVE or NERVOUS about dental treatment?

Are your teeth SENSITIVE to hot, cold, sweets, pressure?

Are you UNHAPPY with the APPEARANCE of your teeth?

Do you have DISCOLORED teeth that bother you?

Would you like your smile to LOOK BETTER or DIFFERENT?

Name of previous Dentist:

City:

State:

How do you feel about your teeth?

Is this your child's first visit to a dentist?

Does your child eat between meals?

Does your child brush teeth upon arising?

Does your child brush teeth before going to bed?

Have there been any injuries to their teeth, such as falls, blows, etc.?

If so, explain:

Has your child had any unfavorable dental experiences?

Has your child ever received a local anesthetic or any form of anesthetic?

Has your child ever had nitrous oxide (laughing gas)?

Has your child ever had a severe reaction to a local anesthetic or nitrous oxide?

What can we do for you TODAY?

FAMILY HISTORY

Has any member of your family or immediate relatives have or had a tendency to the following:	
Early loss of teeth	
Periodontal disease	
High or low blood pressure	
Bleeding tendency	
Stroke	
Heart Disease	
Diabetes	
Over or underweight	
Cancer	
Stomah trouble or ulcers	
Lung disease	
Arthritis	
Nervousness	

What made you choose our office?	
Tell us about your past dental experiences?	
Additional info that you would like to share with us:	

Do you or have you had headaches?
Do you have pain in jaw joints?
Do you have noises in your jaw joints?
Do you have neck pain?
Do you have broken/sensitive teeth?
Do you doze off while reading, watching tv, sitting inactive or in a public place?
Has anyone noticed that you stopped breathing during your sleep?

The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs.

☐ **I hearby authorize the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs.**

Date:	Dentist's Initials: