

Patient Information

1 Personal Data Please print clearly. Your answers are for our records and are considered confidential.

Patient _____
Last First Middle Mr Mrs Ms Miss Dr

I Prefer To Be Called: _____ Sex: M F

Height _____ ft., _____ in. Weight _____ lbs. Age _____

Birth Date _____ / _____ / _____ SS# _____

Single Married Widowed Divorced Separated

If Married, Spouse's Name _____

Your Closest Relative _____

City _____ State _____ Phone _____

If You Are Completing This Form For The Patient, What Is Your Relationship? _____

How Did You Find Out About Our Services? _____

Street Address _____

City _____

State _____ Zip _____

Home Phone _____

Your Employer _____

Your Occupation _____ How Long? _____

Work Phone _____ Ext. _____

Do You Have A Personal Physician? Yes No

If Yes, Physician's Name _____

2 Financial Responsibility Complete this section if responsible party is other than patient.

Party Responsible For This Account _____

Home Address _____

City _____

State _____ Zip _____

Home Phone _____

Relationship To Patient _____

Employer _____

Work Address _____

City _____

State _____ Zip _____

Work Phone _____ Ext. _____

Responsible Party's SS# _____

3 Insurance Complete this section if responsible party is other than patient.

PRIMARY DENTAL INSURANCE:

Insurance Co. Name _____

Mailing Address _____

City _____

State _____ Zip _____

Insurance Co. Phone _____

Policy No. (Plan, Local or Group No.) _____

Name of Insured _____

Relationship To Patient _____

Insured's Birth Date _____ / _____ / _____ Age _____ Sex: M F

Insured's SS# _____

Insured's Employer _____

SECONDARY DENTAL INSURANCE:

Insurance Co. Name _____

Mailing Address _____

City _____

State _____ Zip _____

Insurance Co. Phone _____

Policy No. (Plan, Local or Group No.) _____

Name of Insured _____

Relationship To Patient _____

Insured's Birth Date _____ / _____ / _____ Age _____ Sex: M F

Insured's SS# _____

Insured's Employer _____

4 For The Record In the event of an emergency, is there someone local that we should contact?

Name _____ Home Phone _____

Relationship To Patient _____ Work Phone _____ Ext. _____

5 Dental History Your answer in this section will enable us to help you more effectively.

Why Have You Come To The Dentist Today? _____

Are You Currently In Pain? Yes No

Have You Ever Had A Serious/Difficult Problem Associated With Any Previous Dental Work? Yes No

Do You Now Or Have You Ever Experienced Pain/Discomfort In Your Jaw Joint (TMJ/TMD)? Yes No

Did You Eat Or Drink Anything Within The Last 4 Hours? Yes No

Your General Dental Health Is Good Fair Poor

Do You Like Your Smile? Yes No

Do Your Gums Ever Bleed? Yes No

How Would You Describe Your Comfort Level In The Dental Office?

(Please Circle One)

Very Comfortable 1 2 3 4 5 Very Anxious

Are You Wearing Removable Dental Appliances? Yes No

6 Medical History In this section, check Yes or No, whichever applies, and provide explanations where indicated.

Is Your Current Physical Health Good? Yes No

Are You Currently Under A Physician's Care? Yes No

If Yes, Please Explain: _____

Have You Had A Physical Examination Within The Past Year? Yes No

Has There Been Any Change In Your General Health Within The Past Year? Yes No

Have You Had Any Serious Illness or Operation? Yes No

If Yes, Please Explain: _____

Have You Been Hospitalized Or Had A Serious Illness Within The Past Five (5) Years? Yes No

If Yes, Please Explain: _____

Have You Had Abnormal Bleeding Associated With Previous Extractions, Surgery, Or Trauma? Yes No

Do You Bruise Easily? Yes No

Have You Ever Required A Blood Transfusion? Yes No

If Yes, Explain Circumstances _____

Do You Have Any Blood Disorder Such As Anemia? Yes No

Are You Employed In Any Situation Which Exposes You Regularly To X-Rays Or Other Ionizing Radiation Yes No

Have You Had Surgery, X-Ray Or Drug Treatment For A Tumor, Growth Or Other Condition Of The Head Or Neck? Yes No

Are You Taking Prescription/Over-The-Counter Drugs? Yes No

If Yes, List Each One _____

Have You Ever Had Any Of The Following Diseases, Medical Problems Or Treatments?

- | | | | |
|-------------------------------|---|----------------------------|---|
| Heart Attack / Stroke | <input type="checkbox"/> Y <input type="checkbox"/> N | Psychiatric Problems | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Cancer / Chemotherapy | <input type="checkbox"/> Y <input type="checkbox"/> N | Epilepsy / Seizures | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Rheumatic Heart Disease | <input type="checkbox"/> Y <input type="checkbox"/> N | Diabetes / Tuberculosis | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Artificial Valves / H. Murmur | <input type="checkbox"/> Y <input type="checkbox"/> N | HIV+ / AIDS | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Congenital Heart Defect | <input type="checkbox"/> Y <input type="checkbox"/> N | Venereal Disease | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Heart Surgery / Pacemaker | <input type="checkbox"/> Y <input type="checkbox"/> N | Drug / Alcohol Abuse | <input type="checkbox"/> Y <input type="checkbox"/> N |
| High / Low Blood Pressure | <input type="checkbox"/> Y <input type="checkbox"/> N | Stomach Ulcers / Colitis | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Mitral Valve Prolapse | <input type="checkbox"/> Y <input type="checkbox"/> N | Hemophilia | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Kidney Problems | <input type="checkbox"/> Y <input type="checkbox"/> N | Anemia / Radiation Therapy | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Artificial Bones / Joints | <input type="checkbox"/> Y <input type="checkbox"/> N | Asthma / Allergy | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Artificial Valves | <input type="checkbox"/> Y <input type="checkbox"/> N | Sinus Problems / Hay Fever | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Shingles / Skin Rash | <input type="checkbox"/> Y <input type="checkbox"/> N | Hepatitis / Liver Disease | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Fever Blisters / Sores | <input type="checkbox"/> Y <input type="checkbox"/> N | Inflammatory Rheumatism | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Severe / Frequent Headaches | <input type="checkbox"/> Y <input type="checkbox"/> N | Emphysema / Glaucoma | <input type="checkbox"/> Y <input type="checkbox"/> N |

Are You Allergic To Any Of The Following:

- | | | | |
|--------------------------------|---|---------------------------|---|
| Local Anesthetics | <input type="checkbox"/> Y <input type="checkbox"/> N | Aspirin / Tylenol | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Dental Anesthetics | <input type="checkbox"/> Y <input type="checkbox"/> N | Codeine / Other Narcotics | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Penicillin / Other Antibiotics | <input type="checkbox"/> Y <input type="checkbox"/> N | Barbiturates / Sedatives | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Tetracycline | <input type="checkbox"/> Y <input type="checkbox"/> N | Iodine | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Erythromycin | <input type="checkbox"/> Y <input type="checkbox"/> N | Latex | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Sulfa Drugs | <input type="checkbox"/> Y <input type="checkbox"/> N | Other _____ | |

For Women: Are You Pregnant? Yes No

Are You Nursing? Yes No

Are You Taking An Oral Contraceptive? Yes No

Do You Have Any Problems Associated With Your Menstrual Period? Yes No

Do You Have Any Medical Condition Not Listed Above That You Think I Should Know About? Yes No

If Yes, Please Explain _____

I certify that I have read and understand the above inquiry. I understand that the information I have given today is correct to the best of my knowledge and will be held in the strictest confidence. I acknowledge that it is my responsibility to inform this office of any changes in my medical status. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient _____

Signature of Dentist _____