Patient Information

Patient Name: Date:

Birth date: Gender: Male Female Family Status: Married Single Child

SSN: E-mail Address:

Cell Phone: Home Phone: Work Phone:

Address: City, State & Zip:

Emergency Contact (Not currently living with you): Relationship to Patient:

Address: Phone#:

Referral Information

Whom may we thank for referring you to our office?

Responsible Party Information (Only if patient is under 18)

The responsible part is the parent/legal guardian who will be signing the in-office documents

Responsible Party's Name: Gender: Male Female Relationship:

Birth Date: SSN: E-Mail Address:

Cell Phone: Home Phone: Work Phone:

Address: City, State & Zip:

Primary Dental Insurance Information

Subscriber Name: Birth Date: SSN:

Employer: Patient's Relationship to Subscriber: Self Spouse Child Other

Insurance Carrier: Id#: Group#:

Secondary Dental Insurance Information

Subscriber Name: Birth Date: SSN:

Employer: Patient's Relationship to Subscriber: Self Spouse Child Other

Insurance Carrier: Id#: Group#:

Patient's Health History

Name:_____ Birth Date:_____
Primary Care Physician:_____ Phone#:_____
What is the date (or approximate date) of your last medical exam?_____
Would you consider yourself to be in good health? ☐Yes ☐ No If No, please explain:_____
Please list any medications (including birth control and herbal remedies) and why you are taking them:

Are you currently under the care of a physician due to a specific condition? ☐ Yes ☐ No Please explain: _____
Have you had any changes in your health in the last year? ☐ Yes ☐ No Please explain: _____
Have you been hospitalized within the last 5 years due to a surgery/illness? ☐ Yes ☐ No Please explain: _____

Please indicate if you have ever experienced any of the following:

				Please Explain any checked boxes:
☐*Pre-Med Amox	☐*Pre-med Clind	☐*Pre-med Other	☐Allergy - Aspirin	
☐Allergy - Codeine	☐Allergy - Erythro	☐Allergy - Penicillin	☐ Allergy - Sulfa	
☐ Anemia/Bleeding	☐ Angina Pectoris	☐Arthritis/Rheumatism	☐ Artificial Joints	
☐ Asthma/Respiratory	☐ Blood Disorder	☐Cancer/Tumors	☐ Diabetes	
☐ Epilepsy/Seizures	☐ Fainting Dizziness	☐ Glaucoma	☐ Head Injuries	
☐ Heart Disease/Attack	☐ Heart Murmur	☐ Hepatitis A	☐ Hepatitis B	
☐ Hepatitis C	☐ High Blood Pressure	☐ HIV	☐ Immune Disorder	
☐ Kidney Disease	☐ Liver Disease	☐ Mental Disorder	☐ Nervous Disorder	
☐Osteoporosis	☐ Other	☐ Pacemaker	☐Radiation Treatment	
☐ Rheumatic Fever	☐ Sinus Problems	☐ Stomach Problems	☐ Stroke	
☐ Thyroid	☐ Tuberculosis	☐ Ulcers	☐ Venereal Disease	

Do you have any other conditions , diseases, allergies, etc. not listed above?_____

Please mark any of the following to indicate YES in response to the question:

☐Do you smoke or use smokeless tobacco? ☐Do you use alcohol?
☐Have you had any drug addictions? ☐Have you taken Phen-Fen or similar appetite suppressants?
☐Taken cortisone/steroid medication? ☐For women only: Are you Pregnant?
☐Taken Bisphosphonates? (i.e. Foasamax, Actonel, Boniva, Aredia, Bonefos, Digronel, Zometa)
☐Using CPAP machine?

What is the reason for your dental visit today?_____
When did you last see a dentist?_____ Name:_____ Phone:_____
How frequently do you brush your teeth? ☐ 3(+) a day ☐Twice a day ☐Once a day ☐Weekly ☐Seldom
How frequently do you floss your teeth? ☐ 1(+) a day ☐2-6 weekly ☐1-6 monthly ☐Seldom ☐Never

Please mark any of the following to indicate YES in response to the question:

☐Are any of your teeth causing you pain? ☐Do your gums bleed when you brush or floss?
☐Do you currently have dental implants, dentures, partials? ☐Do you have any loose teeth?
☐Do you grind your teeth (consciously or during sleep)? ☐Are your teeth sensitive to hot or cold?
☐Have you experienced problems with previous dental treatment or local anesthetic?
If you could change anything about your mouth, teeth, or smile, what would it be?_____

I HEREBY CERTIFY THAT THE ANSWERS TO THE FOREGOING QUESTIONS ARE ACCURATE TO THE BEST OF MY ABILITY. SINCE A CHANGE IN MY MEDICAL CONDITON OR IN MEDICATIONS I TAKE CAN AFFECT DENTAL TREATMENT, I UNDERSTAND THE IMPORTANCE OF AND AGREE TO TAKE THE RESPONSIBILTY TO NOTIFY THE DENTIST OF ANY CHANGES AT ANY SUBSEQUENT APPOINTMENT.

Print Name Signature Date
(Patient, legal guardian or authorized agent of patient)