PATIENT INFORMATION

Patient Full Name____ Date of Birth________________ Age_______
First M.I. Last

Social Security #_______________________________________ Male or Female________ Marital Status___________________________

Home address______________________________________ City_____________________ State___________ Zip____________

Home Phone#_________________________ Work phone#_____________________________ Cell phone #________________________

Email______________________________ Preferred method of contact_____________________ Employer______________________________

Emergency Contact___________________________ Emergency Contact Phone #______________________ Relationship__________________

Primary Care Physician___________________________ Physician's Phone #__________________________________

Is patient a full time student?________ Does patient live in a nursing home?__________

Is Any Other Member of Your Family A Patient Here?_________ If Yes, Name______________________________ Relationship__________________

RESPONSIBLE PARTY (if other than patient)

Full Name____ Social Security #____________________________ Date of Birth________________

Address__________________________________ City___________________________ State_______ Zip__________ Phone #________________

Relationship to Patient______________________ Employer_______________________________ Employer Phone #______________________

DENTAL INSURANCE

Primary Dental Insurance

Insured's Name____

Insured's SSN ____

Insured's Date of Birth________________ Relationship to Patient _________

Insured's Employer____

Insurance Company____

Group #______________ Insurance Phone #___________________________

Secondary Dental Insurance

Subscriber name____

Subscriber SSN____

Subscriber Date of Birth_______________Relationship to Subscriber_________

Subscriber Employer____

Insurance Company____

Group #_______________ Insurance Phone #___________________________

please present insurance card to receptionist

How did you hear about us? Please circle one Friend/Relative/ Yellow Pages/Relative/Insurance/Internet Search/Other________________

If you were referred by a friend, whom may we thank for referring you?_____________________________________

DENTAL HISTORY

Why have you come to see us today? (i.e., pain, routine check up, etc.) ____

Are you currently in pain?__________________ Do you have bleeding gums?________________Date of previous dental exam_________________

Reason for changing previous dentist:____

Have you ever had a bad dental experience?____________ If yes, please explain____

Do you require prophylactic antibiotic pre-medication prior to dental treatment?____

Do you or have you ever experienced pain in your jaw joint (TMJ/TMD)?___________

Are you interested in straightening or whitening your teeth? _______Whitening________Straightening

ALLERGIES

Are you allergic to any of the following?

____Aspirin ____Ibuprofen ____Penicillin ____Codeine ____Latex ____Local Anesthesia ____Metal

____Sulfur Drugs ____Acrylic ____Iodine ____Other:_____________________

MEDICAL HISTORY

Are you taking any medications? ____Yes ____No If yes, please list all current medications here:____

____

Do you smoke or use chewing tobacco? ____Yes ____No If yes, which one?__________________

Do you have a history of drug or alcohol abuse? ____Yes ____No If yes, which one?________________

Have you ever taken Fen Phen? ____Yes ____No

Do you have or have you ever had any of the following medical conditions?

____Anemia

____Abnormal Bleeding

____Eating Disorder

____Emphysema

____Fainting Spells

____Hemophilia

____Pacemaker

____Thyroid Disorder

____Seizures

____Liver Problems

____Ulcers

____Sickle Cell Disease

____Artificial Heart Valve

____Chemo or Radiation Treatment

____Heart Attack

____Epilepsy

____Auto Immune Disease

____Acid Reflux

____Frequent Headaches

____Mitral Valve Prolapse

____HIV/AIDS

____Shingles

____Psychological Disorder

____High Blood Pressure

____Sexually Transmitted Disease

____Sinus Problems

____Diabetes

____Other, please specify____

____Artificial Joint Replacement

____Asthma

____Cancer

____Arthritis

____Glaucoma

____Difficulty Breathing

____Rheumatic Fever

____Tuberculosis

____Kidney Problems

____Low Blood Pressure

____Stroke

____Heart Murmur

____Congenital Heart Defect

Women:

Do you take birth control? ____Yes ____No Are you pregnant? ____Yes ____No If yes, how many weeks?_____ Are you nursing?____Yes ____No

I certify that I have read and understand the above. I acknowledge that my questions have been answered truthfully and to the best of my knowledge. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Patient Signature____ Date________________________

Doctor Signature____ Date________________________

Updated:

______Date___________ ______Date___________ ______Date___________ ______Date___________ ______Date___________