

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name) Gender: _____ Marital Status: S M D W Child
Social Security #: _____ Birth Date: ___/___/___
Phone (Home): _____ (Cell): _____
(Work): _____ Ext: _____ Email: _____
Best place for confirmation calls: Home ___ Cell ___ Work ___ Text Message ___ Email ___
Address: _____
Street Apartment #
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> ADD/ ADHD | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Fainting | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tuberculosis |
| | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Growths | <input type="checkbox"/> Penicillin Allergy | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Currently Pregnant | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Head Injuries | Due date: _____ | OTHER: |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Respiratory Problems | _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis A__ B__ C__ | <input type="checkbox"/> Rheumatic Fever | |
| <input type="checkbox"/> Codeine Allergy | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Sinus Problems | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Smoker | |

- Have you ever had a history of drug or alcohol abuse? Yes No
If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
If yes, please explain: _____
- Are you now under the care of a physician? Yes No
If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? Yes No
If yes, please explain: _____
- List any medications you are currently taking: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian _____ Date: _____

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative
 Dental Office Yellow Pages Internet School Insurance Other _____
Name of person or office referring you to our practice: _____

Dental Information

- Have you ever had any complications following dental treatment? Yes No

If yes, please explain: _____

- When was your last dental cleaning? _____

- Are you experiencing any dental pain? Yes No

If yes, please explain: _____

- Are you happy with your smile? Yes No

If no, please explain? _____

- What would you like to change about your smile? _____

- Are you interested in whitening your smile? Yes No
- Are you interested in orthodontics (braces/Invisalign)? Yes No
- Are you interested in replacing missing teeth? Yes No
- Are you aware of clenching or grinding your teeth? Yes No

Responsible Party or Parent/Guardian Information

The following is for: the patient the patient's spouse parent/guardian

Name: _____ Relationship to patient _____
 Male Female Married Single Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____

Address: _____
Street Apartment #
City State Zip Code

Employment Information

The following is for: the patient the parent/ guardian

Employer Name: _____ Phone # _____

Address: _____
Street City, State Zip Code

Insurance Information

Primary

Name of Policy Holder: _____

Policy Holder's Birth Date: _____/_____/_____ Member Id#: _____ Social Security # _____
Last First MI

Name of Insurance _____

Insurance Company's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____